

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Chamberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 days  
 Hospital, institution, or street address where death occurred:  
Allegheny Hospital  
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MD County Allegheny  
 City or town Mt. Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Bald Knob  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Zella Mae Albright

## 3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Charles L. Albright  
 7. Birth date of deceased (mo., day, yr.) June 22, 1911 6.(c) If alive, give age 47 years  
 8. AGE: Years 35 Months 6 Days 26 If less than one day hrs. min.

9. Birthplace Ocean, Allegheny, Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own home  
 12. Name Jesse R. Merrill  
 13. Birthplace Midland, Md  
 14. Maiden name Myrtle J. Keeter  
 15. Birthplace Buttalo Mills, Pa.

16. Informant Charles L. Albright  
 Address Mt. Savage, Md.

17. Burial Date thereof January 20, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Savage Methodist Cemetery  
 Location Mt. Savage, Md.

18. Funeral director John J. Huffer  
 Address Chamberland, Md  
 19. Jan 20 1947 Joe G. Peaslee  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1947 at 12:30 PM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Jan 18 1947  
 and that I last saw him alive on Jan 17 1947  
 Immediate cause of death Carcinoma of liver DURATION 3 yrs  
 Due to Carcinoma of R Breast Recurrent - 2 yrs  
 Due to about 2 years ago  
 Other conditions Aspirin - R Breast  
Carcinoma of liver  
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE P. Allen G. Murray M. D. or other  
 Address Chamberland, Md Date signed Jan 18 1947

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JAN 30 1947

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

### 1. PLACE OF DEATH:

County Allegany  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 72 hours  
Hospital, institution, or street address where death occurred:  
St. Mary's Hospital  
How long in hospital or institution? 72 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Blondike  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2  
(If rural, give LOCATION)  
2.(a) if veteran, name war 2

### 3. (a) FULL NAME

George Baker

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Infant

6.(b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) April 24, 1946 8.(c) If alive, give age 2 years

8. AGE: Years — Months 8 Days 28 If less than one day — hrs. — min.

9. Birthplace National, Allegany Co., Md.  
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER 12. Name George Taylor

13. Birthplace Middleton

MOTHER 14. Maiden name Mary Elizabeth Baker

15. Birthplace Woodland Md.

16. Informant Mary Elizabeth Baker

Address Woodliffe, Md.

17. Burial Burial Date thereof Jan 25, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Patrick's Cemetery

Location Mt. Savage, Md.

18. Funeral director J. E. Eithorn

Address Laurens, Md.

19. 1-24 19 47 Mrs. Nancy N. Roe  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 19 47 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 19 47 to Jan 22 19 47

and that I last saw him alive on Jan 22 19 47

Immediate cause of death Acute Intoxication

Due to —

Due to —

Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE W. McNamee M. D. or other

Address Frostburg Md Date signed 1-24-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 28 1947  
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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0000311

### 1. PLACE OF DEATH:

County Allegheny  
City or town Huntstone (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 61 yrs.  
Hospital, institution, or street address where death occurred: —  
How long in hospital or institution? —

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Allegheny  
City or town Huntstone (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Green Ridge  
(If rural, give LOCATION)  
2.(a) If veteran, name war —

### 3. (a) FULL NAME

Perry Loren Barnes

### 3. (b) Social Security Number

219-03-9824

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife Izora Barnes  
(deceased) 6. (c) If alive, give age — years  
7. Birth date of May 26, 1885  
deceased (mo., day, yr.)  
8. AGE: Years 61 Months 7 Days 27 If less than one day — hrs. — min.

9. Birthplace Allegheny Co., Md.  
(Town, county, and state)  
10. Usual occupation Farmer  
11. Industry or business Own Farm  
12. Name Carlton Barnes  
13. Birthplace Maryland  
14. Maiden name Nancy Hartsack  
15. Birthplace Maryland

16. Informant Lloyd Barnes  
Address Star Route, Huntstone Md.  
17. Burial Date thereof Jan. 26, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Green Ridge Cemetery  
Location Green Ridge Md.  
18. Funeral director Ephraim Smith  
Address Artemus, Ia.

19. Jan 23 19 47 T. T. Mann, per M. E. Mann  
(Data rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1947 at 5:45 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 20, 1947 to Jan. 22, 1947  
and that I last saw him alive on Jan. 22, 1947

Immediate cause of death Angina pectoris DURATION 3 days

Due to —  
Due to —  
Other conditions —  
(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —  
Autopsy results —  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide — Date of —  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) —  
Means of injury — Injured at work? —

23. SIGNATURE J. A. Watson M.D. M. D. or other —  
Address Little Orleans Md. Date signed 1/23/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 28 1947

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Evidence for the change of  
age is shown on  
G 108 2/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 90

00004

1. PLACE OF DEATH:

County Allegany

City or town Franklin  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

156 Spring St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany

City or town Franklin  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 156 Spring St.  
(If rural, give LOCATION)

2.(a) if veteran, name war

3. (a) FULL NAME

Mrs. Alice Beal

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Lamorne Beal

6.(c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) May 27 - 1918

8. AGE: Years 28 Months 8 Days 4 hrs. min.

9. Birthplace Cumberland, Allegany, Md.  
(Town, county, and state)

10. Usual occupation Nurse

11. Industry or business

12. Name Danny Lindsey

13. Birthplace England

14. Maiden name Sarah Jane Snider

15. Birthplace England

16. Informant Mr. Lafayette Beal

Address 156 Spring St. Franklin

17. (Burial, cremation, or removal. Which?) Burial Date thereof Feb 3, 1947  
(month) (day) (year)

Cemetery or crematory Episcopal Cemetery

Location 243 Main St. Franklin

18. Funeral director James H. Davis

Address Franklin, Md.

19. 2-1 47 Mrs. Nancy N. Roe  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1947, at 9 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h. ER. DEAD Jan 31 1947

Immediate cause of death Chronic Myocarditis

DURATION

about  
10 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner Allegany Co

23. SIGNATURE H. V. Remington M. D. or other

Address Cumberland Md Date signed 2-3/47

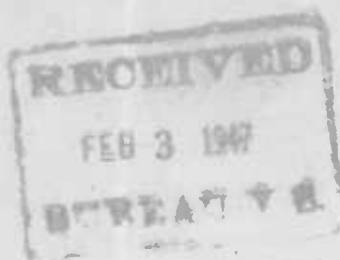
MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00005

## CERTIFICATE OF DEATH

Reg. Diat. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Chamberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 daysHospital, institution, or street address where death occurred: Allegheny HospitalHow long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County MineralCity or town Springfield  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. 1  
(If rural, give LOCATION)2. (a) If veteran, name war. ✓

## 3. (a) FULL NAME

Basil Edward Bennett

## 3. (b) Social Security Number

None

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mary E. Bennett7. Birth date of deceased (mo., day, yr.) March 23, 18706. (c) If alive, give age 73 years8. AGE: Years 76 Months 9 Days 20 If less than one day  
..... hrs. .... min.9. Birthplace Hampshire Co., W. Va.  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Own farm12. Name Martin L. Bennett13. Birthplace Hampshire Co., W. Va.14. Maiden name Marguerite Moreland15. Birthplace Hampshire Co., W. Va.16. Informant Lynn BennettAddress Canton, Ohio17. Burial Date thereof Jan 16, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Ft. Rabbey CemeteryLocation Ft. Rabbey, W. Va.18. Funeral director John J. StoforAddress Chamberland, Md.19. Jan 14 19 47 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 19 47, at 3:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-11-47 to 1-13-47  
and that I last saw him alive on 1-13-47Immediate cause of death Lobar Pneumonia DURATION 4 days

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

Autopsy results Lobar Pneumonia, Myocarditis, Atherosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin, M.D.Address Chamberland, Md. Date signed 1-14-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 21 1947  
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

DR. JACOBSON

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... ALLEGANY  
 City or town..... CIMBERLAND, MD  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... PENNA. County..... Somerset  
 City or town..... ADDISON  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war..... ☒

## 3. (a) FULL NAME

MR. CHARLES BIRD

## 3. (b) Social Security Number

None

## 4. Sex

MALE

## 5. Color or race

WHITE

## 6.(a) Single, married, widowed, or divorced

MARRIED

## 6.(b) Name of husband or wife

BERTHA (NUSS) BIRD6.(c) If alive, give age. 72 years

7. Birth date of deceased (mo., day, yr.)

AUGUST 20, 1871

## 8. AGE:

75

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

PA. Somerset County  
(Town, county, and state)

## 10. Usual occupation

RETIRED FARMER

## 11. Industry or business

FATHER

## 12. Name

JOHN BIRD

## 13. Birthplace

PA.

## 14. Maiden name

CATHERINE SWALPH

## 15. Birthplace

MARYLAND

## 16. Informant

Address

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

## 18. Funeral director

Address

## 19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

4:15 A.M.20. DATE OF DEATH..... JANUARY 5, 1947 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 4 19 47 to Jan 5 19 47  
 and that I last saw him alive on Jan 5 19 47

Immediate cause of death

Coronary Occlusion  
Coronary Artery Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 1/5/47

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JAN 14 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 00007

## 1. PLACE OF DEATH:

County Allegany  
 City or town Rural near Old Town Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution? at 1 Oldtown, Md.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany  
 City or town Rural  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 5 miles east of Old Town Md.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Virginia Anne Bolt

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

Dec 23 1943  
 8. AGE: Years 3 Months 0 Days 11  
 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Irwin Va.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. (Burial, cremation, or removal. Which?)

Burial

## Date thereof

Jan 6 1947  
(month) (day) (year)Cemetery or crematory Oldtown Methodist Cemetery

## Location

## 18. Funeral director

## Address

## 19. (Date rec'd by registrar)

Jan 4 1947

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1947 at 7 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 and that I last saw him/her alive on Dead Jan. 3 1947

Immediate cause of death

Capillary Bronchitis

DURATION

about8 daysDue to Measles

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

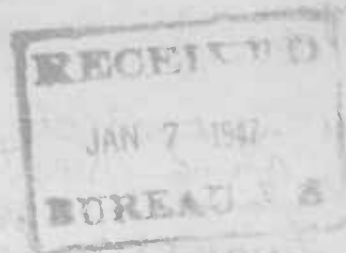
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

Signature H. V. Deming M.D. H. V. Deming M.D.  
 M. D. or other \_\_\_\_\_

Address Chamberland, MdDate signed 1-3-1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County AlleganyCity or town Mt. Savage  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 1/2 yrs.

Hospital, institution, or street address where death occurred:

Old Row

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Mt. Savage  
(If outside city or town limits, write RURAL and give nearest town)Street No. Old Row

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mary Frances Brailer

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleWhiteWidowed6. (b) Name of husband or wife Thomas Brailer

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Dec 28, 18658. AGE: Years Months Days If less than one day  
81 - 22 ..... hrs. .... min.9. Birthplace Mt. Savage, Allegany, Md.  
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name Joseph Miller13. Birthplace Germany14. Maiden name Bridgett Flood15. Birthplace Maryland16. Informant Mrs. Harry GausmanAddress Mt. Savage, Md.17. Burial Date thereof Jan 22 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. PatrickLocation Mt. Savage, Md.18. Funeral director Lois L. Stein, Inc.Address Cumtobert, Md.19. Jan 22 19 47 Vernice McDermott  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 20 January 19 47 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 19 1945 19 45 to January 15 19 47and that I last saw her alive on January 15 19 47Immediate cause of death Carcinoma R. Breast.

## DURATION

several  
years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE William E. Masley M. D. or otherAddress Mt. Savage, Md. Date signed 1-20-47

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JAN 27 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00009

100

## 1. PLACE OF DEATH:

County Allegany  
 City or town Shuttsburg, Mt. Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 years  
 Hospital, Institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State W. Va. County Allegany  
 City or town Shuttsburg, Mt. Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

6. (a) Single, married, widowed, or divorced

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife James R. Bridges

7. Birth date of deceased (mo., day, yr.) Aug. 2nd, 1866 6. (c) If alive, give age 83 years

8. AGE: Years 79 Months 5 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cumberland Valley, Buffalo, Pa.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name James R. Elliott

13. Birthplace Cumberland Valley, Md.

14. Maiden name James R. Elliott

15. Birthplace Cumberland Valley, Md.

18. Informant Mr. Marshall Long

Address Shuttsburg, Mt. Savage, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 1-10-1949  
 (month) (day) (year)

Cemetery or crematorium St. Patrick's

Location Shuttsburg

18. Funeral director James R. Elliott

Address Shuttsburg, Md.

19. Date rec'd by registrar Jan 8, 1949 Registrar Norman McDermott

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH January 6th, 1947 at 12:00 midnight

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 26th, 1946 to January 6th, 1947  
 and that I last saw him alive on January 6th, 1947

Immediate cause of death Cerebral Hemorrhage. DURATION 2 weeks

Due to Vascular Hypertension several years -

Due to \_\_\_\_\_

Other conditions Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William E. Moreley M. D. or other \_\_\_\_\_

Address Mt. Savage, Md. Date signed 1-8-1947

RECEIVED

JAN 10 1947

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany  
City or town Rural) Bowmans Addition  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? About 6 months  
Hospital, institution, or street address where death occurred:  
Upper Road, Bowmans Addition  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Allegany  
City or town Rural) Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. upper road Bowmans Addition  
(If rural, give LOCATION)  
2. (a) If veteran, name war

3. (a) FULL NAME

Mrs. Gertrude Wahl Brown

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced  
6. (b) Name of husband or wife Unknown  
7. Birth date of deceased (mo., day, yr.) Aug 24 1902  
6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 44 Months 5 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cumberland Ind.  
(Town, county, and state)

10. Usual occupation housework

11. Industry or business

12. Name Wm Wahl

13. Birthplace Germany

14. Maiden name Unknown

15. Birthplace

16. Informant Chas E Van Pelt

Address Bowmans Add. Ind

17. (Burial, cremation, or removal. Which?) Burial Date thereof Oct 1 47  
(month) (day) (year)

Cemetery or crematory Wicks Cem.

Location Valley Rd.

18. Funeral director Louis Stein, Jr.

Address Cumberland

19. Jan 31 19 47 J. P. Frankel, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH Jan. 29 19 47 at 5.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him/her alive Dead Jan. 29 19 47

Immediate cause of death

Mesenteric thrombosis

DURATION

at  
once

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Abdominal operation

July 1946  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: It death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

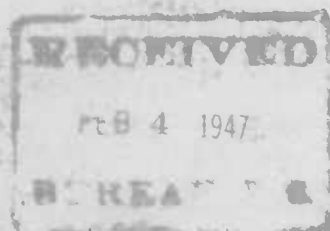
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H. V. Dening, M.D. M. D. or other

Address Cumberland Md Date signed 1/30/47



7-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: **Allegany**  
 County.....  
 City or town..... **Frostburg**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
**Frost Avenue**  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... **Maryland** County..... **Allegany**  
 City or town..... **Frostburg**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **232 Center St.**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... **First World War**

3. (a) FULL NAME  
**JOHN WESLEY BROWN**

3. (b) Social Security Number

**219-03-9516**

4. Sex **Male** 5. Color or race **Colored** 6.(a) Single, married, widowed, or divorced **Single**  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) **November 24, 1889**  
 8. AGE: Years **57** Months **1** Days **28** It less than one day  
 hrs. min.

9. Birthplace..... **Cumberland, Maryland**  
 (Town, county, and state)  
 10. Usual occupation..... **Janitor**  
 11. Industry or business..... **C. & W. Transit Co.**  
 12. Name..... **John W. Brown**  
 13. Birthplace..... **Maryland**  
 14. Maiden name..... **Hannah Williams**  
 15. Birthplace..... **Maryland**

16. Informant..... **Mrs. Idabelle Gordon**  
 Address..... **Frostburg, Md.**

17. **Burial** Date thereof..... **Jan. 25 '47**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... **Allegany**  
 Location..... **Frostburg, Md.**

18. Funeral director..... **J. J. Durst.**  
 Address..... **Frostburg, Md.**

19. **1-24** 19**47** **Mrs. Nancy A. Roe**  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... **Jan 22** 19**47** at **8 A** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him **Dead Jan 22** 19**47**

Immediate cause of death.....

**Chronic Myocarditis**

DURATION **several years**

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Deputy Medical Examiner - **Allegany Co**

23. SIGNATURE..... **H. V. S. M. S.**

M. D. or other

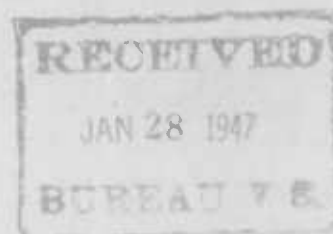
Address..... **Cumberland, Md.**

Date signed **1-22-47**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35-

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 years  
Hospital, institution, or street address where death occurred:  
400 Grand AvenueHow long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 400 Grand Avenue  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

JOHN JOSEPH BURNS

## 3. (b) Social Security Number

705-05-47924. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Zelda May Broadstock  
6.(c) If alive, give age 46 years7. Birth date of deceased (mo., day, yr.) 22 February 19018. AGE: Years 45 Months 11 Days 9 If less than one day hrs. min.9. Birthplace Cumberland, Alleg. Co., Md.  
(Town, county, and state)10. Usual occupation Machinist11. Industry or business B&B RR12. Name John T. Burns13. Birthplace Grafton, W. Va.14. Maiden name Margaret A. Fleming15. Birthplace Piedmont, W. Va.16. Informant Zelda M. BurnsAddress 400 Grand Ave., Cumberland, Md.17. Burial Date thereof 3 FEB 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Mary's CemeteryLocation Cumberland, Maryland.18. Funeral director Louis Steih, Inc.Address Cumberland, Maryland.19. Feb 1, 1947 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 31 January 19 47 at 2:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 46 to Jan. 31 19 47  
and that I last saw him alive on Jan. 30 19 47Immediate cause of death Chronic myocarditisDue to Coronary Artery 3mmDue to Coronary Artery 3 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Furr M. D. or otherAddress Cumberland Date signed 31/47

MARGIN RESERVED FOR BINDING

9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Miners' Hospital  
 How long in hospital or institution? 7 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Allegany  
 City or town..... Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Standish St  
 (If rural, give LOCATION)  
 2.(a) If veteran, Name war..... 1st World War

## 3. (a) FULL NAME

William H. Carder

## 3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 22, 1887  
 6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day  
59 8 9 hrs. min.

9. Birthplace..... Glencoe Penna.  
 (City, town, county, and state)

10. Usual occupation..... miner11. Industry or business..... Coal mines12. Name..... James Carder13. Birthplace..... Maryland14. Maiden name..... Nettie Robinson15. Birthplace..... Maryland16. Informant..... Edward CarderAddress..... Frostburg, Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof..... Jan. 4 1947  
 (month) (day) (year)Cemetery or crematory..... St. MichaelsLocation..... Frostburg Md.18. Funeral director..... J. J. ChristAddress..... Frostburg Md.19. 1-3 47 Ms. Nancy H. Roe  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 1 1947 at 935 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan 1 1947 to Jan 1 1947  
 and that I last saw him alive on Jan 1 1947

Immediate cause of death.....  
Cerebral Hemorrhage  
Left Hemisphere

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Wm. Lane Jr. M.D.  
 M. D. or otherAddress..... Frostburg Md. Date signed 1-3-47

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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## CERTIFICATE OF DEATH

Reg. Dist. No. ....

DR. GRACIE

## 1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 70 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLANDCounty... ALLEGANYCity or town... CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. 687 FAYETTE ST.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

CARROLL, GERTRUDE MRS.

## 3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

CARROLL, HOHN M.6. (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.)

MARCH 1, 1881

8. AGE:

Years

Months

Days

If less than one day

651018

hrs.

min.

9. Birthplace

MARYLAND, CUMBERLAND

(Town, county, and state)

10. Usual occupation

HOUSE WIFE

11. Industry or business

MOTHER FATHER

12. Name

SHYROCK, HENRY

13. Birthplace

MARYLAND

14. Maiden name

HUFF, ALICE

15. Birthplace

MARYLAND

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MARYLAND17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 22 1947  
(month) (day) (year)

Cemetery or crematory

Ross Hill

Location

935 Fayette St. 3D

18. Funeral director

J. E. Waltons

Address

Cumberland, Md.19. Jan 2119. 1947at St. B. Franklin M.D.

(Date rec'd by registrar)

Registrar

22. SIGNATURE

W.G. Gracie

M. D. or other

Address

Cumberland, Md.Date signed Jan 19 47

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 19, 1947

19

10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1519 46

to

Jan 1819 47

and that I last saw her alive on

Jan 1819 47

Immediate cause of death

DURATION

Carcinomatous  
Pathological fracture  
of hip -  
Carcinoma of breast

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

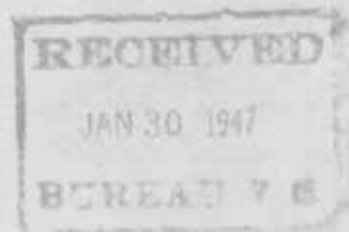
Injured at work?

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

### 1. PLACE OF DEATH:

County Allegheny  
City or town Greensburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 Days  
Hospital, institution, or street address where death occurred Memorial Hospital  
How long in hospital or institution? 2 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Pa County Erie  
City or town P. 2 Greentown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Simon Caton

### 3. (b) Social Security Number

212-10-9258

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Minnie Caton

7. Birth date of deceased (mo., day, yr.) September 20, 1893 6.(c) If alive, give age 43 years

8. AGE: Years 53 Months 4 Days 10 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Greenville Township, Pa.  
(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Fire clay mines

12. Name George Caton

13. Birthplace Pennsylvania

14. Maiden name Nancy Albright

15. Birthplace Pennsylvania

16. Informant Clarence Caton

Address Frostburg, Md.

17. Burial, cremation, or removal. Which? Burial Date thereof Feb 3, 1947  
(month) (day) (year)

Cemetery or crematory Greenville

Location Greenville Pa.

18. Funeral director J. J. Dierst

Address Frostburg Md.

19. 2-2 47 Ms. Harvey A. Roe  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31st 19 47 at 5:35 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 46 to Jan 31 19 47  
and that I last saw him alive on Jan 30 19 47

Immediate cause of death Pneumonia DURATION 2 days

Due to Chronic Bronchitis 3 yr

Due to Silicosis 6 yr

Other conditions \_\_\_\_\_

(Include pregnancy within 6 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE P. Alan E. Murray

Address Circleville Date signed Feb 1/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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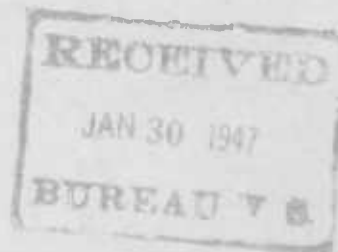
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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 yrs.  
 Hospital, institution, or street address where death occurred:  
527 N. Center St.,  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 527 N. Center St.,  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

IDA MAY CHENOWITH

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife George E. Chenowith  
 6. (c) If alive, give age 63 years  
 7. Birth date of deceased (mo., day, yr.) July 4, 1878  
 8. AGE: Years 68 Months 6 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Westernport, Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business  
 12. Name John Howearth  
W. Va.  
 13. Birthplace Elizabeth ?  
 14. Maiden name Unknown  
 15. Birthplace

16. Informant George E. Chenowith  
 Address 527 N. Center St., Cumberland, Md.  
 17. Burial Rose Hill Cem.  
 (Burial, cremation, or removal. Which?) Cumberland, Md.  
 Date thereof Jan. 23, 1947  
 (month) (day) (year)  
 Cemetery or crematory  
 Location Charles L. George  
Cumberland, Md.  
 18. Funeral director  
 Address

19. Jan. 23, 1947 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20, 1947, at 2:45 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1945 to Jan. 20, 1947  
 and that I last saw him alive on Jan. 15, 1947

Immediate cause of death Hypertensive C.V. Disease  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE B. M. Shindler M. D. on other \_\_\_\_\_  
 Address 41 Green St. Date signed Jan 24, 1947

MARGIN RESERVED FOR BINDING

VS A15 9.45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1947

BUREAU 78

2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

72a

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## CERTIFICATE OF DEATH

Reg. Dist. No.

4

## 1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 18 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... PENNSYLVANIA County BEDFORDCity or town... SIX MILE RUN  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) if veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

MARIAN CLARK

## 3. (b) Social Security Number

None

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, married, widowed, or divorced \_\_\_\_\_

FEMALE WHITE MARRIED6. (b) Name of husband or wife EARL CLARK7. Birth date of deceased (mo., day, yr.) 6-21-19086. (c) If alive, give age 44 years

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_

38 7 0 hrs. \_\_\_\_\_ min.

9. Birthplace Pennsylvania  
(Town, county, and state)10. Usual occupation HOUSE

11. Industry or business \_\_\_\_\_

12. Name HECK, GEORGE13. Birthplace PA.14. Maiden name TRUAX, MYRTLE15. Birthplace PA.16. Informant Earl ClarkAddress Six Mile Run, Pa.17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 1-25-47  
(month) (day) (year)Cemetery or crematory Deval CemeteryLocation Six Mile Run, Pa.18. Funeral director R.E. HuffAddress Somerset, Pa.19. Jan. 22, 47 J. O. Franklin  
(Date rec'd by registrar) (M.O. Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1947 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 3, 1947 to Jan. 21, 1947and that I last saw him alive on Jan. 21, 1947

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

ProfoundDue to Hemorrhage

(Toxic)

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 6 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. O. Franklin M.D. or other \_\_\_\_\_Address Cumberland Date signed 1-22-47

MARGIN RESERVED FOR BINDING

VS A15 9-45,15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1947

BUREAU V 6

2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

74a

00019

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Cumberland,  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7 Roberts St.,

How long in hospital or institution?

## 3. (a) FULL NAME

David Clinton Cline

## 3. (b) Social Security Number

214-05-9386

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Grace Poorbaugh Cline

## 7. Birth date of deceased (mo., day, yr.)

Oct. 14, 1895

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

51

Months

3

Days

13

If less than one day

hrs.

min.

## 9. Birthplace

Thomas, W. Va.

(Town, county, and state)

## 10. Usual occupation

Street Dept. Employee  
City of Cumberland

## 11. Industry or business

FATHER

## 12. Name

Alfred Cline

## 13. Birthplace

W. Va.

MOTHER

## 14. Maiden name

Lena Giffin

## 15. Birthplace

W. Va.

## 16. Informant

Mrs. Grace Cline

## Address

7 Roberts St., Cumberland, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 30, 1947

(month) (day) (year)

## Cemetery or crematory

Hill Crest Cem.

## Location

Cumberland, Md.

## 18. Funeral director

H. Wayne George

## Address

Cumberland, Md.

## 19. Jan. 30, 1947

(Date rec'd by registrar)

19 47

J. P. Franklin, M.D.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Allegany.....

City or town..... Cumberland,  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 7 Roberts St.,  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 27, 1947 10:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1/27/47 1947 to 1/27/47 1947

and that I last saw deceased alive on 1/27/47 1947

Immediate cause of death

Coronary Thrombosis

## DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 4 1947  
BURLINGTON

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 206 Thomas St.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

William F. Conis

## 3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.)

January 13, 1947

8. AGE:

Years

Months

Days

If less than one day

8 hrs.0 min.

9. Birthplace

Cumberland, Allegheny, Md.  
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER

12. Name

William Conis

13. Birthplace

Cumberland, Md.

14. Maiden name

Mary I. Hestard

15. Birthplace

Cumberland, Md.

16. Informant

William ConisAddress 206 Thomas St. Cumberland, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof January 17, 1947  
(month) (day) (year)

Cemetery or crematory

St. Mary's Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Hestard

Address

Cumberland, Md.

19.

Jan. 14, 47  
(Date rec'd by registrar)

19.

J. P. Franklin, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1947, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 13, 1947 to January 13, 1947  
and that I last saw him alive on January 13, 1947

Immediate cause of death

Pneumonia

DURATION

8 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. M. Schindler, M.D.  
M. D. or other

Address

41 GreenleafDate signed Jan 17, 1947

RECEIVED

JAN 21 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00021

80

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Pittsburgh  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 57 years  
 Hospital, institution, or street address where death occurred:  
Charleston Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegheny  
 City or town Pittsburgh  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Charleston Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Mary Wilson Cook

## 3. (b) Social Security Number

C

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife D. Arch Cook

7. Birth date of deceased (mo., day, yr.) March 4, 1888 6. (c) If alive, give age 57 years

8. AGE: Years 58 Months 10 Days 24 If less than one day

9. Birthplace Coal Creek, Colorado (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

12. Name William Wilson

13. Birthplace England

14. Maiden name Eliza Hendra

15. Birthplace England

16. Informant Mrs. James Ray

Address Winstemport Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan. 31, 1947 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Ponacoring Md.

18. Funeral director M. Eichhorn

Address Ponacoring Md.

19. Jan 31 1947 (Date rec'd by registrar) Registrar Jonathan B. Boal

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1947 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 28 1947

and that I last saw him alive on Jan 27 1947

Immediate cause of death Diabetic Mellitus DURATION 3 yrs.

Due to Diabetic Coma 2 day

Due to

Other conditions Multiple hemorrhage 2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

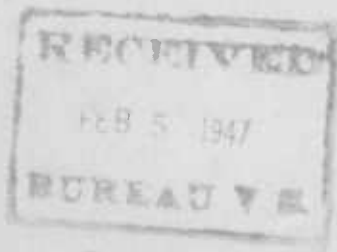
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Norman Reeves M.D. M. D. or other

Address Winstemport Md. Date signed 1-29-47



2-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

### 1. PLACE OF DEATH:

County Allegany  
City or town Madison  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 44 yrs  
Hospital, institution, or street address where death occurred:  
Railroad Street  
How long in hospital or institution? 1

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Madison  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Railroad Street  
(If rural, give LOCATION)  
2. (a) If veteran, name war no

### 3. (a) FULL NAME

David Darnley

### 3. (b) Social Security Number

219-03-9032

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Anna Hotchkiss Darnley  
5. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Aug. - 1879

8. AGE: Years 68 Months 4 Days 26 If less than one day  
hrs. min.

9. Birthplace Pekin, Allegany Co., Maryland  
(Town, county, and state)

10. Usual occupation Rubber Worker

11. Industry or business Kelley Springfield Tire Co.

12. Name John Darnley

13. Birthplace Scotland

14. Maiden name Catherine Mackay

15. Birthplace Scotland

16. Informant John Darnley

Address Lake, Ind.

17. Burial Date thereof Jan. 3, 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Madison, Md.

18. Funeral director W. Cichborn

Address Madison, Md.

19. Jan. 3 19 47 Edith M. Coal  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 19 47 at 3 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 47 to Jan 1 19 47  
and that I last saw him alive on Dec 20 19 46

Immediate cause of death Chronic Bronchitis +  
Bronchial Asthma

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

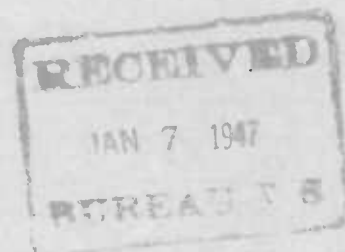
23. SIGNATURE Henry M. Hodgson M.D.

Address Madison, Md. Date signed Jan 2 19 47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 00023 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 11 Frederick St., McFarlane Bldg.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Matthew A. Davis

## 3. (b) Social Security Number

236-12-9603

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Ella Conway  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 3, 1882  
 8. AGE: Years 64 Months 8 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Kingsville, West Virginia  
 (Town, county, and state)

10. Usual occupation Manager11. Industry or business Apt. House

MOTHER FATHER  
 12. Name Matthew Davis  
 13. Birthplace Ireland  
 14. Maiden name Ann Brady  
 15. Birthplace Ireland

16. Informant Mrs. James H. Burke  
 Address Cumberland, Md.

17. Burial Date thereof Jan. 11, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Mary's Cem.  
 Location Near Cumberland, Md.

18. Funeral director Louis Stein, Inc.  
 Address Cumberland, Md.

19. Jan. 10, 19 47 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/9/47 19\_\_\_\_ at A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/25/46 19\_\_\_\_ to 1/9/47 19\_\_\_\_  
 and that I last saw him/her alive on 1/9/47 19\_\_\_\_

Immediate cause of death

Pneumonia (aspirated)  
obscured  
 Due to Pneumonia lobes

DURATION

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Not done

Date of op. \_\_\_\_\_

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE John R. Rozum u D M. D. or other

Address Cumberland, Md. Date signed 1/14/47

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 16 1947

BUREAU 78

1-35

ALLEGANY COUNTY HEALTH DEPARTMENT  
CUMBERLAND, MARYLAND

INTER OFFICE COMMUNICATION

Date January 14, 1947.

To: Dr. A. W. Hedrich

From: Dr. J. P. Franklin

Remarks:

The attached certificate of Matthew A. Davis, who died in Cumberland, Maryland, January 9, 1947, was not forwarded with the weekly returns of yesterday, Monday, January 13, 1947, because the findings of the Pathologist were not made known to the attending physician, Dr. John K. Rozum until today, January 14, 1947.

Permission was granted the Funeral Directors, Louis Stein, Inc., to inter the body on January 10, 1947, because it was not certain when the pathological findings would be known.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00024

Reg. Dist. No.

40

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

409 Decatur

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County MunialCity or town Burlington  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2. (a) If veteran, name war. ☒

## 3. (a) FULL NAME

Joseph Arnold Donovan

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Bernine Hathaway Donovan

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

Apr. 23 - 1869

## 8. AGE:

Years 77 Months 8 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Grant Co. W. Va.

(Town, county, and state)

10. Usual occupation Retail Farmer.

## 11. Industry or business

FATHER John Donovan13. Birthplace W. Va.MOTHER Caroline Evans14. Maiden name W. Va.15. Birthplace W. Va.16. Informant Bevel DunsenAddress Redmont W. Va.17. McDowell Cemetery Date thereof Jan 11 - 47  
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory McDowell CemeteryLocation Burlington W. Va.18. Funeral director W. H. FiedrichAddress Redmont W. Va.19. 1. 10 19 47  
(Date rec'd by registrar) Registrar B. Franklin M. D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 19 47 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 26 19 46 to Jan. 8 19 47and that I last saw him alive on Jan 8 1947 19 47Immediate cause of death Glandular DURATION \_\_\_\_\_Carcinoma infectingall glands of the body

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E. Kester M. D. or other \_\_\_\_\_Address 122 Bedford St. Cumberland Date signed 1-9-47  
md.

MARGIN RESERVED FOR BINDING

9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In street age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital  
 How long in hospital or institution? seven days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State W. Va. County Preston  
 City or town Terra Alta  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Mary A. Elliott

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Isaac F. Elliott

7. Birth date of deceased (mo., day, yr.) 10/9/1898  
 6. (c) If alive, give age 48 years

8. AGE: Years 48 Months 3 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace W. Va.  
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Ridenour, Dave13. Birthplace Unknown14. Maiden name Bird, Alice15. Birthplace Unknown

16. Informant Memorial Hospital  
 Address Cumberland, Maryland

17. Time of Removal Date thereof Jan. 24, 47  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Terra AltaLocation Terra Alta, W. Va.18. Funeral director A. F. CullenAddress Terra Alta, W. Va.

19. Jan. 24 19 47 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1947 at 10:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 47 to Jan 24 19 47  
 and that I last saw him alive on Jan 24 - 47

Immediate cause of death

Survived death  
 Due to operation upon  
 Due to fall bladder with  
stones.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

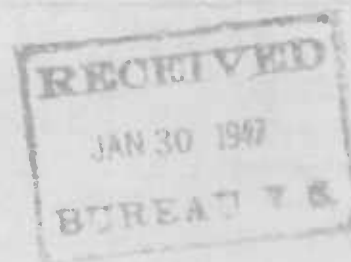
23. SIGNATURE A. H. Kaulkeus M. D. or other

Address Daugherty Date signed 1-24

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

215 Cumberland St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 215 Cumberland St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Anna D. Farrell

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Rush H. Farrell  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Feb. 24, 1882  
 8. AGE: Years 64 Months 10 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Westernport, Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John C. Getty  
 13. Birthplace Maryland

14. Maiden name Mary C. Koontz  
 15. Birthplace Maryland

16. Informant Mr. Hubert Farrell  
 Address 215 Cumberland St. Cumberland, Md.

17. Burial Date thereof Jan. 6, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Patricks Cem.  
Cumberland, Md.  
 Location \_\_\_\_\_

18. Funeral director Charles L. George  
 Address Cumberland, Md.

19. Jan. 5, 1947 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3, 1947 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2, 1948 to Jan. 3, 1947  
 and that I last saw him alive on 1/2 19 47

Immediate cause of death congestive heart failure  
arteriosclerotic  
heart disease

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions hypertension  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

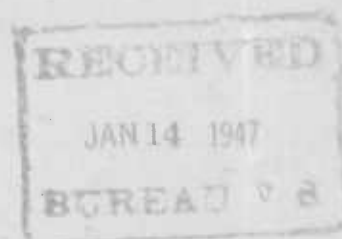
Injured at home, farm, industry, pub'c place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John A. Getty, M.D.  
Long, Md. M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 1/5/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35-

Outside of  
City limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00027

Reg. Dist. No. 40

### 1. PLACE OF DEATH:

County Allegheny  
City or town Near Cumberland (Rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
La Vale, R.F.D. #1

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny  
City or town Near Cumberland (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. La Vale, R.F.D. #1  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

Ervin O. Fazenbaker

### 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Stella Hawk

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1867

8. AGE: Years Months Days If less than one day  
79 5 9 hrs. min.

9. Birthplace Anderson Run, Garrett Co. Ind.  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Jesse Fazenbaker

13. Birthplace Ind.

14. Maiden name Margarette Diamond

15. Birthplace Ind.

16. Informant Mrs. Lou Lang

Address Cumberland

17. Burial Date thereof Jan 9 '47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Philos Cem

Location Westonport Ind

18. Funeral director Louis Stein Inc

Address Cumberland

19. Jan 8 19 47 Joseph W. Douglas, M.D.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 19 47 at 4:40 A.M.

21. I CERTIFY that death occurred on the day above stated; that I attended deceased from  
12/8/46 19 46 to 1/6/47 19 47

and that I last saw him alive on 1/6/47 19 47

Immediate cause of death

Pneumonia - broncho  
(1017) (47046)

Due to complications of age

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE R. J. Williams  
M. D. or other

Address Cumberland Ind Date signed 1/6/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2396

RECEIVED

JAN 14 1947

BUREAU OF

2-35-

*R. J. Williams*

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? most lifetime

Hospital, institution, or street address where death occurred:

Allegany County InfirmaryHow long in hospital or institution? 1 week

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 635 Elm Street

(If rural, give LOCATION)

2.(a) If veteran, name war No

## 3. (a) FULL NAME

Jacob David Fishell

## 3. (b) Social Security Number

None

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

divorced

## 6. (b) Name of husband or wife

Estella Long Fishell7. Birth date of deceased (mo., day, yr.) July 4 18646. (c) If alive, give age 45 years

## 8. AGE:

Years

Months

Days

If less than one day

82529

hrs.

min.

9. Birthplace Spring Gap, Mineral, West Virginia

(Town, county, and state)

10. Usual occupation Retired11. Industry or business B.O.R.R. Trockman12. Name Jacob Fishell13. Birthplace Spring Gap W. Va.14. Maiden name ?15. Birthplace ?16. Informant John FishellAddress 635 Elm St, Cumberland, Md.17. Burial Date thereof Jan 6 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forest Glen CemeteryLocation Green Spring W. Va.18. Funeral director John J. BakerAddress Cumberland, Maryland19. Jan 6 19 47 J. P. Franklin, M.D.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 19 47 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 28 19 46 to Jan 3 19 47and that I last saw him Jan 2 19 47 alive onImmediate cause of death Acute myocardial Failure

DURATION

3 hrs.Due to Chronic myocarditis 10 yr 23Due to Atherosclerotic disease 15 yr 5

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

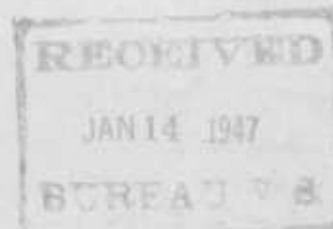
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D.

M. D. or other

Address 110 S. Centre St. Date signed 1-6-47



2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

00029

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 hoursHospital, institution, or street address where death occurred:  
AlleganyHow long in hospital or institution? 13 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 312 Franklin  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Gottlieb Forster Frederick Forster

## 3. (b) Social Security Number

217-10-6878

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white widower6. (b) Name of husband or wife Pearl Forster7. Birth date of deceased (mo., day, yr.) January 26, 1894  
6. (c) If alive, give age years8. AGE: Years Months Days If less than one day  
52 11 27 hrs. min.9. Birthplace Cumberland, Allegany, Md.  
(Town, county, and State)10. Usual occupation Bartender11. Industry or business Retail Liquor12. Name John F. Forster13. Birthplace Germany14. Maiden name Catherine Weigand15. Birthplace Germany16. Informant Katherine ForsterAddress 312 Franklin St.17. Burial Date thereof January 25, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest cemeteryLocation Cumberland, Md.18. Funeral director John J. HooperAddress Cumberland, Md.19. Jan. 25, 1947 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 19 47 at 12.25 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead Jan. 23 19 47Immediate cause of death Intercrainal hemorrhage DURATION 13 hrs.Due to self inflicted bullet wound in skullDue to despondency

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 1-22-47Where did injury occur? Cumberland Allegany Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) 523 N. Center St.  
Shot self with a 38  
Means of injury calibre revolver Injured at work? yes23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.  
M. D. or otherAddress Cumberland Md Date signed 1-23-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1947

BUREAU V. B.

1-35

DR. FRED WILLIAMS

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00030

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1.5 yearsHospital, institution, or street address where death occurred:  
MEMORIAL HOSPITALHow long in hospital or institution? 5 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)Street No. 603 PIEDMONT AVE.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

FLOYD GARLAND

## 3.(b) Social Security Number

092-10-9159

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE WHITE MARRIED6.(b) Name of husband or wife THELMA HECKMAN7. Birth date of deceased (mo., day, yr.) SEPTEMBER 29, 1900 6.(c) If alive, give age 42 years8. AGE: Years 46 Months 47 Days 3 If less than one day  
hrs. min.9. Birthplace MARYLAND  
(Town, county, and state)10. Usual occupation AGENT... SINCLAIR REF. CO.

## 11. Industry or business

12. Name JACOBS GARLAND13. Birthplace PA.14. Maiden name CLARA DESHONG15. Birthplace PA.16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof January 19, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Thomas CemeteryLocation St. Thomas, Pa.18. Funeral director John J. W. W.Address Cumberland, Md.19. Jan 28 19 47 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 26, 1947 at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

10-15-1946 to 1-26-1947  
and that I last saw him alive on 1-26-1947

Immediate cause of death

Cardiovascular  
renal disease.  
(Nephritis)Due to W.R.

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

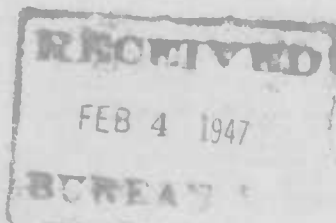
Means of injury Injured at work?

23. SIGNATURE W.F. Williams  
M.D. Co-attestAddress Cumberland Date signed 1-27-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY  
City or town CUMBERLAND, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 67 DAYS2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State MARYLAND County ALLEGANY  
City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 616 H. CENTRE ST.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

GOLDIE SHEARS GARLITZ

## 3. (b) Social Security Number

214-16-2087

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALEWHITEDIVORCED6. (b) Name of husband or wife Roy Garlitz7. Birth date of deceased (mo., day, yr.) JUNE ? 1906

6. (c) If alive, give age. years

8. AGE: Years 40 Months 6 Days ? If less than one day  
hrs. min.9. Birthplace KINGWOOD, W. VA.  
(Town, county, and state)10. Usual occupation housework

## 11. Industry or business

12. Name HENRY SHEARS13. Birthplace W. Va.14. Maiden name DAISY SHROUT15. Birthplace W. Va.16. Informant Daisy Gladis Garlitz  
Address Cumberland Ind.17. Burial & Removal Date thereof Jan 17, 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Camp Green Con.Location Turkeytown W. Va.18. Funeral director Loring StricklandAddress Cumberland19. Jan 16 19 47 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH JAN. 14, 19 47, at 10:35 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Nov 8 19 46 to JAN 14 19 47  
and that I last saw h. ER alive on JAN 10 19 47Immediate cause of death CANCER UTERUS

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NONE

Date of op.

Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M. D. or otherAddress Memorial Hospital Date signed 1-15-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 21 1947

BUREAU V S

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

HODGES

159

00032

Reg. Dist. No.

4

## 1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 HOURS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? CUMBERLAND 4 HOURS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND DONACONING  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

BABY GIRL GETTY

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALEWHITESINGLE

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) JANUARY 14, 19478. AGE: Years Months Days If less than one day  
4 hrs. min.9. Birthplace CUMBERLAND, ALLEGANY, MD.  
(Town, county, and state)10. Usual occupation NEWBORN

11. Industry or business \_\_\_\_\_

12. Name GORMAN E. GETTY13. Birthplace MARYLAND14. Maiden name NELSON, JOSEPHINE15. Birthplace MASSACHUSETTS16. Informant MEMORIAL HOSPITALAddress CUMBERLAND17. Cremation Date thereof 1 16 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MEMORIAL HOSPITALLocation CUMBERLAND, MARYLAND18. Funeral director Same as above

Address \_\_\_\_\_

19. Jan. 16 19 47 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 14, 1947 at 9:30 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan. 16 to Jan. 16 19 47  
and that I last saw him alive on Jan. 16 19 47

Immediate cause of death

Perinatal

DURATION

5 pm

Due to

Due to

Other conditions

Myomectomy of  
meconium-stained birth  
(Include pregnancies within 3 months of death)

Major findings of operations

MyomaDate of op. 1/13/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE W. P. Hodges

M. D. or other

Address \_\_\_\_\_ Date signed \_\_\_\_\_

RECEIVED

JAN 21 1947

BUREAU V S

1-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

130

00033

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Flintstone  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 19 Years  
 Hospital, Institution, or street address where death occurred:  
Rural Flintstone  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Allegany  
 City or town..... Flintstone  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Rural  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Howard Glasser

## 3. (b) Social Security Number

None

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married  
 6.(b) Name of husband or wife..... Elizabeth Nelson Grasser  
 6.(c) If alive, give age..... 65 years  
 7. Birth date of deceased (mo., day, yr.)..... February 11 1868  
 8. AGE: Years..... 78 Months..... 11 Days..... 9 If less than one day..... hrs. .... min.

9. Birthplace..... Pennelton Co., West Virginia  
 (Town, county, and state)  
 10. Usual occupation..... Farmer  
 11. Industry or business..... "  
 12. Name..... Unknown  
 13. Birthplace..... "  
 14. Maiden name..... "  
 15. Birthplace..... "

16. Informant..... Samuel Grasser  
 Address..... Flintstone, Md.  
 17. Burial Date thereof..... Jan 21 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Strawser Cemetery  
 Location..... Flintstone, Md.  
 18. Funeral director..... William H. Kight  
 Address..... Cumberland, Md.  
 19. Jan 23 1947 Theresa L. Bender  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 20 1947 at 10-05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec. 3 1946 to Jan 20 1947  
 and that I last saw him alive on Dec. 27 1946

Immediate cause of death..... Bright's diseaseDue to..... Acute nephritis  
10/22/43Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... J. A. Watson M.D.  
 Address..... Little Orleans, Md. Date signed..... 1/20/47  
 M. D. or other

RECEIVED

JAN 27 1947

BUREAU OF

1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 00034 4

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

307 Grand Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 307 Grand Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Charles Clarence Green

## 3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Matty Childs7. Birth date of deceased (mo., day, yr.) Sept 15 1897 6. (c) If alive, give age 47 years8. AGE: Years 54 Months 3 Days 22 less than one day hrs. min.9. Birthplace Cumberland Ind.  
Town, county, and state10. Usual occupation Postmaster11. Industry or business High School12. Name Chas. C. Green13. Birthplace Baltimore Ind.14. Maiden name Margaret Kresser15. Birthplace Baltimore Ind.16. Informant Vincent GreenAddress Cumberland17. Burial Date thereof Jan 10 '47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Marys Cem.Location Cumberland18. Funeral director Roma Stein Inc.Address Cumberland19. Jan 9 19 47 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 19 47 at 10:40 A.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 19 46 to Jan. 7 19 47and that I last saw him alive on Jan. 6 19 47Immediate cause of death MyocardialinfarctionDue to Coronary ArteryatherosclerosisDue to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of Jan 7 1947

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) NoneMeans of injury None Injured at work? None23. SIGNATURE Clayton J. Green M. D. or other NoneAddress Cumberland Date signed 1/7/47

RECEIVED

JAN 14 1947

BUREAU V S

1-35

DR.W.F.WILLIAMS

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00035

12/a

4

## 1. PLACE OF DEATH: ALLEGANY

County

City or town CUMBERLAND, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

11 days

3. (a) FULL NAME Elizabeth  
MRS. ELSIE HAGGERTY

3. (b) Social Security Number

214-07-6444

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife HARRY HAGGERTY

7. Birth date of  
deceased (mo., day, yr.)

OCTOBER 3-1915

6. (c) If alive, give age 32 years

8. AGE:

Years

Months

Days

If less than one day

31

3

16

hrs.

min.

9. Birthplace WEST VIRGINIA  
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

MOTHER FATHER

12. Name DON McDONALD

13. Birthplace WEST VIRGINIA (Romney)

14. Maiden name BESSIE ARNOLD

15. Birthplace WEST VIRGINIA

16. Informant Thery Haggerty

Address

17. Burial, cremation, or removal. Which?

Date thereof

Jan. 21, 1947

Cemetery or crematory

Peadar Point Cem.

Location

Keyser, St. Va.

18. Funeral director

Address

13. Mr. Markwood

Keyser, W. Va.

19. (Date rec'd by registrar)

Jan. 20, 1947 Jas. B. Franklin, Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State WEST VIRGINIA

County MINERAL

City or town

KEYSER

(If outside city or town limits, write RURAL and give nearest town)

Street No.

566 SOUTH STREET

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

JANUARY 19, 1947

2:00 A.M.

20. DATE OF DEATH..... 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 8, 1947, to Jan 15, 1947

and that I last saw him alive on Jan 18, 1947

Immediate cause of death

DURATION

Chronic Hepatitis

Due to Hypertension

Due to Chronic Anemia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45/5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1947

BUREAU 76

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. R. WILLIAMS

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00036

4

## 1. PLACE OF DEATH:

County ALLEGANY  
 City or town CUMBERLAND, MARYLAND  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

7 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State District of Columbia County Washington  
 City or town Washington D.C.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

218-03-7019

## 3. (a) FULL NAME

FERRY EVERETT HARE

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

DIVORCED

6. (b) Name of husband or wife

Anna Yaste Hare

7. Birth date of

deceased (mo., day, yr.) NOV. 25 1897

6. (c) If alive, give age. years

8. AGE:

Years 49

Months 1

Days 20

If less than one day

hrs.

min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

TRUCK DRIVER

11. Industry or business

FATHER

12. Name

WESLEY HARE

13. Birthplace

MD.

MOTHER

14. Maiden name

ANNIE STARK

15. Birthplace

MD

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19 47

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 15 19 47 6:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/8/47 19 to 1/15/47 19

and that I last saw him alive on 1/16/47 19

Immediate cause of death

Coronary thrombosis

Due to

Coronary sclerosis

Due to

Other conditions

Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

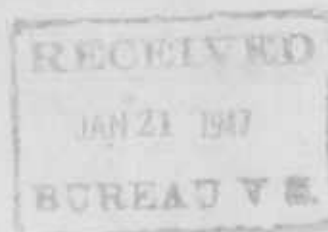
23. SIGNATURE

M. D. or other

Address

Date signed

1/15/47



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00037

4

DR. SCHINDLER

## 1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)Street No. 222 N. CENTRE ST.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

MR. JAMES HARRIS

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALECOLOREDSINGLE

## 6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 18 71 6.(c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

about 75

hrs.

min.

9. Birthplace PENNA.  
(Town, county, and state)10. Usual occupation JANITOR

## 11. Industry or business

12. Name JAMES HARRIS13. Birthplace PENNA14. Maiden name LIZA WILSON15. Birthplace PA.16. Informant Memorial Hosp.Address Cumberland, Md.17. Burial Date thereof Jan 27, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cey.Location Cumberland, Md.18. Funeral director Louis Stein, Inc.Address Cumberland, Md.19. Jan 25, 1947 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## 3.(b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1947 at \_\_\_\_\_ M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 15, 1947 to January 22, 1947and that I last saw him alive on January 22, 1947

Immediate cause of death \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

23. SIGNATURE B. M. Schindler, M.D. M. D. or otherAddress 41 Green St. Date signed Jan 30, 1947

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JAN 30 1947

BUREAU 78

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

### 1. PLACE OF DEATH:

County Allegany  
City or town Miners Hospital Frostburg Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 16 hours  
Hospital, institution, or street address where death occurred:  
Miners Hospital Frostburg Md.  
How long in hospital or institution? 16 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 112 N. Cedar St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war.

### 3. (a) FULL NAME

Charles G. Hauger

### 3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single  
6. (b) Name of husband or wife  
7. Birth date of deceased (mo., day, yr.) Aug. 26, 1928  
6. (c) If alive, give age ..... years  
8. AGE: Years 18 Months 4 Days 5 If less than one day ..... hrs. .... min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 19 47 at 7.20 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....  
and that I last saw him Dead Jan. 1 19 47  
Immediate cause of death .....  
Basal fracture of the skull 16 hrs.  
& severe concussion of the brain  
Due to automobile accident.  
Due to .....  
Other conditions .....  
(Include pregnancy within 3 months of death)

### DURATION

9. Birthplace Cumberland, Md.  
(Town, county, and state)  
10. Usual occupation Student  
11. Industry or business Fork Union Military Academy  
FATHER 12. Name Ward N. Hauger  
13. Birthplace Terra Alta, W. Va.  
MOTHER 14. Maiden name Nina Cornwell  
15. Birthplace Cumberland, Md.  
16. Informant Ward N. Hauger  
Address 112 N. Cedar St. Cumberland, Md.  
Burial Date thereof Jan. 4, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Hillcrest Cem.  
Cumberland, Md.  
Location Charles L. George  
18. Funeral director Cumberland, Md.  
Address  
19. Jan 6 19 47 Mar. Nancy N. Roe Registrar  
(Date rec'd by registrar)

Major findings of operations ..... Date of op. ....  
Autopsy results .....  
PHYSICIAN: Please underline the cause to which death should be charged statistically  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide accident Date of 1.1.47  
6.1/2 mi. west of  
Where did injury occur? Cumberland Allegany Md.  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) Route 40  
Going East, skidded on snow, rear side  
Means of injury hit by another car, going west  
23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.  
M. D. of other  
Address Cumberland Md Date signed Jan 2, 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 8 1947

BUREAU OF

1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00039

## 1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

1 HR 5 MIN.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANYCity or town... CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)Street No. 65 GREEN ST.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

RICHARD MERRILL HELKER

## 3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) 4/2/46

8. AGE:

Years

Months

Days

If less than one day

928

hrs.

min.

9. Birthplace... CUMBERLAND, MARYLAND  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name... JOHN L. HELKER13. Birthplace... MD14. Maiden name... EDITH MURRAY15. Birthplace... W. VA.16. Informant... Memorial HospitalAddress... Cumberland, Md.17. Burial Date thereof... Feb. 3, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... HillCrest Cem.Location... Cumberland, Md.18. Funeral director... Charles L. GeorgeAddress... Cumberland, Md.19. Feb. 1, 1947 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 1-30 19 47 at 10:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-28 19 47 to 1-30 19 47  
and that I last saw him alive on 1-30 19 47

Immediate cause of death

Virus Respiratory Infection  
Toxic Convulsions

DURATION

3 days2 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following.

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

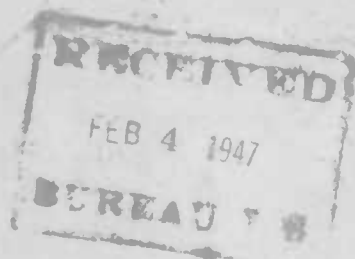
23. SIGNATURE

H. P. Franklin  
126 Yuma St. Cumberland Md. M. D. or other  
Address Date signed 2/30/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County... Allegheny  
 City or town... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 70 Years  
 Hospital, institution, or street address where death occurred:  
Allegheny Hospital  
 How long in hospital or institution? 1 Day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegheny  
 City or town... Near Cumberland, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Balto Pike Rt. # 2  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles Marion Hendrickson

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Rosella Middleton  
 7. Birth date of deceased (mo., day, yr.) August 21 1876  
 8. AGE: Years 70 Months 4 Days 19 If less than one day hrs. min.

9. Birthplace... Cumberland, Rt. 2 Allegheny Co. Md.  
 (Town, county, and state)

10. Usual occupation... Farmer11. Industry or business... Farming12. Name... Thornton Hendrickson13. Birthplace... Rt 2, Cumberland, Md14. Maiden name... Amanda Gurley15. Birthplace... Cumberland, Md.16. Informant... Charles A. HendricksonAddress Rt #2, Cumberland, Md.

17. Burial Date thereof 1/8/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Pleasant Grove CemeteryLocation... Rt. #2, Cumberland, Md.18. Funeral director... William H. KightAddress Cumberland, Md.

19. Jan 6 19 47 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... January 5 19 47 at 11-05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death... Terminal pneumonia

DURATION

one dayDue to Multiple myeloma -2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results... multiple myeloma

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address... Date signed

CERTIFICATE OF DEATH

RECEIVED

JAN 14 1947

BUREAU 7 6

2-38

HODGES

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 1 Day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Morgan  
 City or town Paw Paw  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Claude  
Junior Hiatt

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) December 14, 1946

8. AGE: Years Months Days If less than one day

19 hrs. min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Infant

11. Industry or business

12. Name Claude Hiatt13. Birthplace West Virginia14. Maiden name Amy Hutchinson15. Birthplace West Virginia16. Informant Memorial Hospital  
Address Cumberland, Maryland17. Burial Date thereof 1/7/47  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Woodrow CemeteryLocation Paw Paw WVA18. Funeral director H. D. ParksAddress Berkeley Springs WVA19. Jan 5, 47 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 19 47, at 9:00p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 3 19 47 to Jan 3 19 47  
 and that I last saw him alive on 9:00 P.M. 1/3 19 47

Immediate cause of death

Confluent lobular pneumonia

DURATION

1 day

Due to

Due to

Other conditions

Dehydration

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

Lobular Pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Andriat Stitarolic, M.D.  
M. D. or otherAddress Memorial Hospital Date signed 1/6/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 14 1947

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2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00042

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 55 YearsHospital, institution, or street address where death occurred:  
447 Henderson Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 447 Henderson Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Annie Margaret Himmler

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleWhiteMarried6. (b) Name of husband or wife William J. Himmler6. (c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) December 14 18728. AGE: Years Months Days If less than one day  
74 0 20 hrs. min.9. Birthplace Mt Savage, Allegany Co., Maryland  
(Town, county, and state)10. Usual occupation House11. Industry or business "12. Name Peter Logsdon13. Birthplace Mt Savage, Md.14. Maiden name Ellen Brennen15. Birthplace Frostburg, Md.16. Informant William J. HimmlerAddress 447 Henderson Ave, Cumberland, Md.17. Burial Date thereof 1/7/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Peter & Paul CemeteryLocation Cumberland, Md.18. Funeral director William H. KightAddress Cumberland, Md.19. Jan. 6 19 47 J. P. Faulkner, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 19 47 at 2 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
12/30 19 46 to 1/4 19 47  
and that I last saw him alive on 1/4/47Immediate cause of death Cerebral HemorrhageDue to Hypertension

Due to

Other conditions  
(Include pregnancy within 3 months of death)Major findings of operations  
Date of op.Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Rozum M.D.  
M. D. or otherAddress Cumberland Md Date signed 1/4/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 14 1947

BUREAU V S

2-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00043

Reg. Dist. No.

40

### 1. PLACE OF DEATH:

County Allegany Md.  
City or town rural) Brasher Rd. near Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany Md.  
City or town rural) Brasher Rd. near Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. about 1/8 miles off Williams Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Leslie Hugo Hinkle

### 3. (b) Social Security Number

220-10-2045

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

November 19, 1863

8. AGE:

Years

Months

Days

If less than one day

63

2

24

hrs.

min.

9. Birthplace

Near Cumberland, Alleg Co., Md.  
(Town, county, and state)

10. Usual occupation

Labourer

11. Industry or business

Odd jobs

FATHER

12. Name

JAMES H. Hinkle

MOTHER

13. Birthplace

Md.

14. Maiden name

Susan V. Williamson

15. Birthplace

Md.

16. Informant

Mrs. Lester Hinkle

Address

610 Maryland Ave, City

17.

(Burial, cremation, or removal, Which?)

Date thereof

Jan 26 1947  
(month) (day) (year)

Cemetery or crematory

Rock Hill

Location

Cumberland Md.

18. Funeral director

Charles L. George

Address

Cumberland Md.

19.

(Date rec'd by registrar)

Jan 26 1947

J. P. Hanklin, M.D.  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23

19 47 at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him Dead Jan. 23

19 47

Immediate cause of death

Cerebral hemorrhage

DURATION

at once

Due to Arterio-sclerosis

several

Due to

years

Other conditions apoplexy, previous to this attack  
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner Allegany

23. SIGNATURE H. V. Deming M.D.

M. D. or other

Address Cumberland Md.

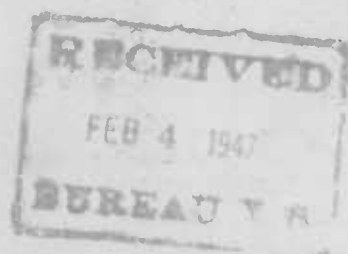
Date signed 1-23-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Outside of City Limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
 Memorial Hospital

How long in hospital or institution?

3 Weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany  
 City or town..... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... 200 Decatur St  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Thomas Lee Holliday

## 3. (b) Social Security Number

235-12-8135

4. Sex..... Male  
 5. Color or race..... White  
 6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Mary Catherine McDonald

6.(c) If alive, give age..... 67 years

7. Birth date of deceased (mo., day, yr.)..... May 14 1888

8. AGE: Years..... 58 Months..... 7 Days..... 29  
 If less than one day..... hrs. .... min.

9. Birthplace..... West Union, Doddridge Co., W. Va.  
 (Town, county, and state)

10. Usual occupation..... Sealing Mines

11. Industry or business..... W.P.A.

12. Name..... Thomas Holliday

13. Birthplace..... West Union, W. Va.

14. Maiden name..... Unknown Bland

15. Birthplace..... West Union, W. Va.

16. Informant..... Mrs. Thomas L. Holliday

Address..... 200 Decatur St, Cumberland, Md.

17. Burial..... Date thereof..... Jan 16/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Greenmount Cemetery

Location..... Cumberland, Maryland

18. Funeral director..... William H. Kight

Address..... Cumberland, Md.

19. Jan. 16..... 19 47 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 13, 19 47 at 11-05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 20, 19 46 to Jan. 13, 19 47  
 and that I last saw him alive on Jan. 13, 19 47

Immediate cause of death.....

DURATION

Acute Myocardial Failure 5 min.  
 Generalized arterio-sclerotic  
 hypertensive disease 8 yrs.

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... Arthur F. Jones M.D.

M. D. or other

Address..... 110 S. Centre St. Date signed..... Jan. 14, 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 21 1947

BUREAU

1-35

# CUMBERLAND, Md. of City Limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

### CERTIFICATE OF DEATH

Reg. Dist. No. 000454

#### 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Windsor Road, The Dingle

How long in hospital or institution?

#### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 206 Greene St.  
(If rural, give LOCATION)

2. (a) If veteran, name war

#### 3. (a) FULL NAME

Lilla May Holmes

#### 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1874

8. AGE: Years Months Days If less than one day  
72 8 6 hrs. min.

9. Birthplace Pittsburgh, Penna.  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Josiah Holmes

13. Birthplace England

14. Maiden name Sarah Wilton

15. Birthplace Penna.

16. Informant Mrs. S. Lua Sykes

Address Windsor Road, The Dingle, Cumberland

17. Burial Date thereof Jan. 18, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Jan. 18 19 47 Joseph B. Zamboni  
(Date rec'd by registrar) Registrar

#### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1947 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 Dec. 46 to 15 Jan. 47 and that I last saw him alive on 15 Jan. 47

Immediate cause of death arteriosclerotic heart disease with terminal failure DURATION 3 wks.

Due to

Due to arteriosclerotic heart disease?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lu A. Van derhey M. D. or other

Address Cumbr. Md. Date signed 16 Jan. 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 21 1947

BUREAU V B

1-35

DR. WILSON

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00046

40

## 1. PLACE OF DEATH:

County ALLEGANY  
City or town CUMBERLAND, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HospitalHow long in hospital or institution? 6 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. VA. County Hampshire  
City or town SHANKS  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

IRA HOTT

## 3. (b) Social Security Number

None

## 4. Sex

MALE

## 5. Color or race

WHITE

## 6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife MONA HOTT6. (c) If alive, give age 44 years7. Birth date of deceased (mo., day, yr.) July 27, 1895

8. AGE: Years Months Days If less than one day

51 6 2 hrs. min.9. Birthplace W. VA.  
(Town, county, and state)10. Usual occupation FARMING11. Industry or business Own farm12. Name SILAS HOTT13. Birthplace W. VA.14. Maiden name FLORENCE HERBAUGH15. Birthplace W. VA.16. Informant Mrs. Ida HottAddress Shanks, W. Va.17. Burial Date thereof Jan 31, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt Zion CemLocation Near Augusta, W. Va.18. Funeral director Wm. McKeeAddress Augusta, W. Va.19. Jan 31, 1947 J. P. Frankish, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 29, 1947 at 2:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 23 - 1947 to Jan 29, 1947  
and that I last saw him alive on Jan 29, 1947

Immediate cause of death

Shock following  
Caesarean sectionDue to Adenocarcinoma of  
stomach

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma stomach  
Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

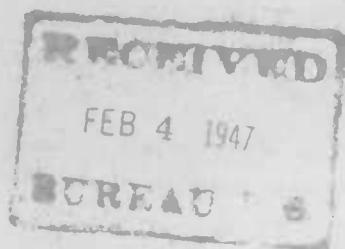
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E. M. Wilson, M.D.  
M. D. or other \_\_\_\_\_Address Cumberland, Md. Date signed 1-30-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 yrs.

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 17 Fifth St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

David Henry Jarvis

## 3. (b) Social Security Number

705-07-8732

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Esther Va. Schmidt

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct 19, 1896

8. AGE:

Years

Months

Days

It less than one day

50224

hrs.

min.

9. Birthplace

Shenandoah Junction, Jefferson Co. W. Va.  
(Town, county, and state)

10. Usual occupation

Retired Engineer

11. Industry or business

B & O. Railroad

MOTHER FATHER

12. Name

David H. Jarvis

13. Birthplace

Shepherdstown, W. Va.

14. Maiden name

Anna Nora, Manuel

15. Birthplace

Shenandoah Junction W. Va.

16. Informant

May Bennett

Address

530 Belair Ave - Apt 101 E

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Jan 15, 1947  
(month) (day) (year)

Cemetery or crematory

Hillcrest Cemetery

Location

Cumberland Md

18. Funeral director

John J. Hafer

Address

Cumberland Md

19. Jan 14, 1947

(Date rec'd by registrar)

J. P. Franklin, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 19 47 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/8/47 19 47 to 1/13/47 19 47and that I last saw him alive on 1/13/47 19 47

Immediate cause of death

Chronic Myocarditis

DURATION

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 1/13/47

RECEIVED  
JAN 21 1947  
BUREAU OF

2-35-47  
P.P.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e

00048

## CERTIFICATE OF DEATH

Reg. Dist. No. 157e

## 1. PLACE OF DEATH:

County Allegany  
 City or town mt Savage, md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County allegany  
 City or town mt Savage, md  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Robert Clifford Jenkins

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced.

male white Single

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) July 6, 1943  
 6. (c) If alive, give age. .... years

8. AGE: Years 3 yrs 6 mo. 15 days If less than one day  
 hrs. .... min.

9. Birthplace mt Savage, md  
 (Town, county, and state)

10. Usual occupation.

11. Industry or business

12. Name John William Jenkins13. Birthplace mt Savage, md14. Maiden name Mrs Virginia Luckey15. Birthplace Louisa, md16. Informant John William JenkinsAddress mt Savage, md

17. (Burial, cremation, or removal. Which?) Burial Date thereof 11-24-47  
 (monthly, days, year)

Cemetery or crematory Methodist CemeteryLocation mt Savage, md18. Funeral director Jacob HaferAddress 23 E Main St, Hootsburg, md19. Jan 22 - 19 47 Jennies M. Emmett

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 21<sup>st</sup> 19 47 at 3:50 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1<sup>st</sup> 19 47 to January 21<sup>st</sup> 19 47  
 and that I last saw him alive on January 21<sup>st</sup> 19 47

Immediate cause of death Influenza -

DURATION

2 weeks -

Due to.

Due to.

Other conditions

Congestive heart disease -  
open foramen ovale -  
 (Include pregnancy within 8 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. .... Date of .....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

William E. Mosley  
mt Savage, md  
 M. D. or other  
 Date signed 11-22-47

RECEIVED

JAN 27 1947

BUREAU

1-35

Outside of  
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

00049

Reg. Diet. No.

1. PLACE OF DEATH:

County... Allegany  
City or town... Rural) near Cumberland, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Fell dead on road.  
Hospital, institution, or street address where death occurred:  
Mt. Savage Rd. in W. Md. Tunnel about 50  
feet from west end  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... Md. County... Allegany  
City or town... Homewood Add. near Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.

3. (a) FULL NAME

Henry M. Knieriem

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white Married

6. (b) Name of husband or wife Mary E. Deal

6. (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) March 20 1869

8. AGE: Years Months Days If less than one day  
77 9 27 hrs. min.

9. Birthplace Cumberland, Allegany, Maryland  
(Town, county, and state)

10. Usual occupation Resturant Owner (retired)

11. Industry or business

FATHER 12. Name William C Knieriem

13. Birthplace Germany

MOTHER 14. Maiden name Martha Widerman

15. Birthplace Germany

16. Informant Eldon O Paxton

Address Mt. Savage Road, Cumberland, Md.

17. Burial Date thereof Jan 20 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Memorial Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Date rec'd by registrar Jan 20 47

Registrar J. B. Locklin

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1947 at 10.30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead Jan. 17 1947

Immediate cause of death

Coronary embolus at once

Due to Arterio-sclerosis

Other conditions (Previous) Apoplexy

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature H. V. Deming M.D.

Address Cumberland Md.

Date signed Jan 17/47

MARGIN RESERVED FOR BINDING

9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1947

BUREAU V S.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d ★

00050

Reg. Dist. No.

90

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4.5 years

Hospital, institution, or street address where death occurred:

99 Washington St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County AlleghenyCity or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 99 Washington St.  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Conrad Kroll

7. Birth date of deceased (mo., day, yr.)

Dec-6-1878

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

68119

hrs.

min.

9. Birthplace

Shaft, Allegheny, Md.  
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

John Ort

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Mr. H. Kroll  
103 Washington St. Frostburg

17.

(Burial, cremation, or removal. Which?)

Date thereof

1-28-1947  
(month) (day) (year)

Cemetery or crematory

Allegheny Cemetery  
Frostburg, Md.

Location

18. Funeral director

Jacob Miller  
Frostburg

Address

19.

1-27  
(Date rec'd by registrar)

19.

47 Mrs. Nancy N. Roe  
Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 19 47 at 3:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 10 19 46 to January 25 19 47.and that I last saw him er alive on January 25 19 47.

Immediate cause of death

Hypertensive Cardio-  
vascular disease

DURATION

5 mos.

Due to

Due to Arterio Sclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

H.C. Siehl, M.D.  
M.D. or other  
Address Frostburg, Md. Date signed 1/27/47

RECEIVED

JAN 29 1947

BUREAU V S

1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 64 yrs

Hospital, institution, or street address where death occurred:

825 Columbia Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 825 Columbia Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Frederick J. Kieffner

## 3. (b) Social Security Number

217-10-4904

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Anne Trautman

7. Birth date of deceased (mo., day, yr.)

Sept 21, 1882

6. (c) If alive, give age..... years

8. AGE:

Years 64 Months 3 Days 12 hrs. min.

9. Birthplace

Cumberland Ind.  
(Town, county, and state)

10. Usual occupation

Trachomist

11. Industry or business

Celapense Corp.

12. Name

John Kieffner

13. Birthplace

Germany

14. Maiden name

Elizabeth Hartung

15. Birthplace

Germany

16. Informant

Robert Kieffner

Address

Cumberland

17. Burial

(Burial, cremation, or removal. Which?)

Trinity Luth. Cem.

Cemetery or crematory

Cumberland

Location

18. Funeral director

John Steis Inc

Address

Cumberland19. Jan 7 1947  
(Date rec'd by registrar)J. P. Franklin, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 19 47 at 10:30 P.M.

21. I CERTIFY that death occurred on the date time stated; that I attended deceased from

December 25, 46 to January 3, 47

and that I last saw him alive on

January 3, 47

Immediate cause of death

Carcinoma of Stomach

DURATION

6 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Franklin, M.D.  
Address Cumberland, Md. Date signed 1-6-47

RECEIVED

JAN 14 1947

BUREAU OF

2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

DR. W.F. WILLIAMS

## 1. PLACE OF DEATH:

County ALLEGANY  
City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 1 DAY

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town FLINTSTONE RT 1  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

MRS. LASHLEY

## 3. (b) Social Security Number

None4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Henry Lashley7. Birth date of deceased (mo., day, yr.) MARCH 17 1874 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 72 Months 10 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace MARYLAND  
(Town, county, and state)10. Usual occupation HOUSEWIFE11. Industry or business Own home12. Name ISAAC WILSON13. Birthplace MARYLAND14. Maiden name CATHERINE ASH15. Birthplace MARYLAND16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof January 14, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lashley Family CemeteryLocation Near Flintstone, Md.18. Funeral director John T. HaferAddress Cumberland, Md.19. Jan 14 19 47 J. P. Franklin M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 12 19 47 at 6:20 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7:31 19 45 to 1-12-47and that I last saw him alive on 1-11-47

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Chronic MyocardialDue to Regeneration

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W.F. Williams M.D. or other \_\_\_\_\_Address Cumberland Date signed 1-13-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

00051

RECEIVED

JAN 21 1947

BUREAU V 8

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and briefly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1572

00052

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days  
 Hospital, institution, or street address where death occurred:

Allegany Hospital  
 How long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany  
 City or town near Cumberland Rural  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Route 1  
 (If rural, give LOCATION)

2 (a) If veteran, name war

## 3. (a) FULL NAME

Baby Boy Loar

## 3. (b) Social Security Number

None

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

January 18, 1947

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

002

hrs.

min.

## 9. Birthplace

Cumberland, Allegany, Md  
(Town, county, and state)

## 10. Usual occupation

Infant

## 11. Industry or business

FATHER

## 12. Name

## 13. Birthplace

MOTHER

## 14. Maiden name

## 15. Birthplace

## 16. Informant

James H. Burkhardt  
Rt. 1, Cumberland, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof January 22, 1947  
(month) (day) (year)

## Cemetery or crematory

Hillcrest Cemetery

## Location

Cumberland, Md.

## 18. Funeral director

## Address

John J. Hoffman  
Cumberland, Md.

## 19.

(Date rec'd by registrar)

19

47Jan 22471947Jan 22471947Jan 22471947Jan 22471947Jan 22471947Jan 22471947Jan 22471947Jan 2247

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1947 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

January 18 1947 to January 20 1947  
 and that I last saw him alive on January 20 1947

Immediate cause of death

respiratory failure

DURATION

2 days

Due to

congenital malformation of the brain

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. H. Hines M.D.

M. D. or other

Address

59 Greene St.

Date signed

1-22-47

RECEIVED

JAN 30 1947

BUREAU 78

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1572 - 00053

Reg. Dist. No. 6

## 1. PLACE OF DEATH:

County Allegany  
 City or town Westonport  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days  
 Hospital, institution, or street address, where death occurred:

Kean Clinic  
 How long in hospital or institution? 2 days

## 3. (a) FULL NAME

JAMES CLEMENT LOGSDON, JR.

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 25 JAN 1947  
 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

2

hrs.

min.

## 9. Birthplace

Westonport Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name JAMES CLEMENT LOGSDON, JR.  
 13. Birthplace BARTON, Md.

14. Maiden name MARY WANDA DIEHLING  
 15. Birthplace WESTONPORT, Md.

## 16. Informant

JAMES CLEMENT LOGSDON, JR.  
BARTON, Md.

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof JAN 28, 1947  
(month) (day) (year)Cemetery or crematory ST. Peter's CemeteryLocation WESTONPORT, Md.

## 18. Funeral director

ELLISWORTH J. BOUL  
 Address 111 Church St. Westernport

19. Jan. 27 19 47  
 (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Barton  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Lawrence  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH 27 January 19 47, at 1:30 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 27 19 47 to on 27 19 47  
 and that I last saw him alive on Jan 27 19 47

Immediate cause of death

congenital heart disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 1/27/47

RECEIVED

JAN 30 1947

BUREAU V S

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

932

00054

Reg. Dist. No.

90

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 67 years  
 Hospital, institution, or street address where death occurred: Meigs Hospital  
 How long in hospital or institution? 5 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md. County Allegheny  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 170 Centre St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Alexander Mac Leger

## 3. (b) Social Security Number

214-22-3868

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Mary Willette  
 7. Birth date of deceased (mo., day, yr.) Apr. 13th 1878 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 67 Months 8 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Consolidation, Allegheny, Md.  
 (Town, county, and state)

10. Usual occupation Retired Coal Miner

11. Industry or business

12. Name Robert Mac Leger

13. Birthplace Scotland

14. Maiden name Edna M. Leger

15. Birthplace Scotland

16. Informant Jessie M. Leger

Address 480 2nd Avenue, Frostburg, Md.

17. Burns (Burial, cremation, or removal. Which?) Date thereof 1-4-1947  
 (month) (day) (year)

Cemetery or crematory Allegheny

Location Frostburg, Md.

18. Funeral director Joseph Crifer

Address Frostburg, Md.

19. 1-2 19 47 Wm. Harvey A. Roe  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 19 47 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30 19 46 to Jan 1 19 47

and that I last saw him alive on Jan 1 19 47

Immediate cause of death Chr. Myocarditis

## DURATION

Several years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. Harvey A. Roe M. D. or other

Address Frostburg Md. Date signed 1-2-47



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

552

00055

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County Alli-gany  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

125 Arch St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Alli-ganyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 125 Arch St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sarah B Mahaney

## 3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife James W. Mahaney7. Birth date of deceased (mo., day, yr.) May 14 1877 6. (c) If alive, give age 40 years8. AGE: Years 69 Months 8 Days 11 If less than one day hrs. min.9. Birthplace Bedford Co. Pa.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name George W. Owens13. Birthplace Pa.14. Maiden name Elizabeth Kirchner15. Birthplace Pa.16. Informant Mrs. Arthur BrownAddress Baltimore Md.17. Burial Date thereof Jan 28 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcreek Cem.Location Baltimore18. Funeral director Louis Stein Inc.Address Baltimore19. Jan. 28 47 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1947 at 3:30 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1946 to Jan 25 1947 and that I last saw her alive on Jan 25 1947Immediate cause of death SarcinomaDue to sarcoma of Cervical gland 1 yr.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Jones M. D. or otherAddress Baltimore Date signed 1/27/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

Within corporate file - Call George

R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore  
CERTIFICATE OF DEATH

94a

00056

Reg. Dist. No. 4

1. PLACE OF DEATH:  
County ALLEGANY  
City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
How long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State WEST VIRGINIA County MINERAL  
City or town RIDGELEY  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. BLOCKER STREET  
(If rural, give LOCATION)  
2.(a) If veteran, name war ☒

3. (a) FULL NAME GEORGE McABEE  
3. (b) Social Security Number None

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED  
6.(b) Name of husband or wife SUSAN HERSHBERGER  
7. Birth date of deceased (mo., day, yr.) SEPTEMBER 19, 1879 6.(c) If alive, give age 67 years  
8. AGE: Years 67 Months 3 Days 20 If less than one day hrs. min.

9. Birthplace MARYLAND (Town, county, and state)  
10. Usual occupation TRUCKER  
11. Industry or business Own Business  
12. Name FRANKLIN McABEE  
13. Birthplace WEST VIRGINIA  
14. Maiden name MARION RICE  
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL  
Address CUMBERLAND, MARYLAND  
17. Burial Date thereof Jan. 13, 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory HillCrest Burial Park  
Location Cumberland, Md.  
18. Funeral director Charles L. George  
Address Cumberland, Md.  
19. Jan 19 19 47 J. P. Franklin, M.D. Registrar  
(Date rec'd by registrar)

MEDICAL CERTIFICATION  
20. DATE OF DEATH JANUARY 9 19 47 at 11:45 P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3, 1947 to Jan 9, 1947  
and that I last saw him alive on Jan 9, 1947  
Immediate cause of death Coronary Thrombosis  
Due to Pneumonia  
Other conditions  
(Include pregnancy within 8 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE [Signature] M. D. or other  
Address Cumberland, Md. Date signed 1/9/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 21 1947

BUREAU V S

12-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Westport, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 days  
Hospital, institution, or street address where death occurred:  
Allegheny HospitalHow long in hospital or institution? 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County AlleghenyCity or town Westport  
(If outside city or town limits, write RURAL and give nearest town)Street No. 100  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Francis Mc Bee7. Birth date of deceased (mo., day, yr.) Feb. 28, 18816. (c) If alive, give age 65 years8. AGE: Years 65 Months 10 Days 17 It less than one day hrs. min.9. Birthplace Cresaptown, Allegheny, Md.  
(Town, county, and state)10. Usual occupation Watch-maker11. Industry or business R. R. W. M. Co.12. Name Frank Mc Bee13. Birthplace W. Va.14. Maiden name Mary Hudson15. Birthplace W. Va.16. Informant John Mc Bee, Jr.Address Westport, Md.17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan 18, 1947  
(month) (day) (year)Cemetery or crematory St. Ambrose Cem.Location Cresaptown, Md.18. Funeral director E. J. H. S. S. S.Address Westport, Md.19. Jan 15 19 47 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

705-10-7555

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 19 47 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 47 to 19 47and that I last saw him on Dead Jan 15 19 47Immediate cause of death Intestinal abdominal hemorrhage 10 days

DURATION

Due to Intestinal polypoma 6 months

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N. V. Deming, M.D. M. D. or otherAddress Cumberland, Md. Date signed 1-15-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK

DATE OF DEATH

DEPARTMENT OF HEALTH

RECEIVED

JAN 21 1947

BUREAU V.S.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

00058

40

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....ALLEGANYCity or town.....CUMBERLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?.....2 days

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution?.....2 DAYS

## 3. (a) FULL NAME

BABY BOY MILLER

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

JAN. 29, 1947

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

002

hrs.

min.

9. Birthplace.....

MARYLAND (CUMBERLAND.)

(Town, county, and state)

10. Usual occupation.....

INFANT

11. Industry or business.....

FATHER

12. Name.....

HAROLD MILLER

13. Birthplace.....

MD. Cumberland

14. Maiden name.....

WILDA JOHNSON

15. Birthplace.....

MD. Cumberland

16. Informant.....

Harold J. Miller

Address.....

48 Humbird St., Cumberland, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

Feb. 1, 1947  
(month) (day) (year)

Cemetery or crematory.....

Zion Memorial Park

Location.....

Cumberland, Md.

18. Funeral director.....

John J. Hefner

Address.....

Cumberland, Md.

19.

(Date rec'd by registrar)

19

47J. P. Franklin, M.D.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

MARYLAND

County.....

ALLEGANY

City or town.....

48 HUMBIRD ST.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

CUMBERLAND, MD.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....JAN. 31.....1947.....at 3:50A.....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

29 Jan.....1947.....to 31 Jan.....1947and that I last saw him.....alive on 31 Jan 47.....19.....

Immediate cause of death.....

Respiratory Failure

DURATION

Due to.....

Prematurity, 6-7 hrs.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please undertake the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

Julian B. Whitworth

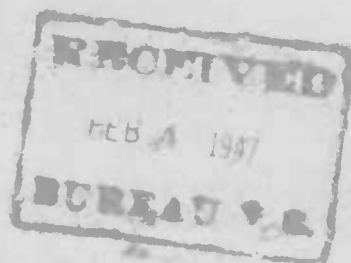
M. D. or other

Address.....

112 Bedford St

Date signed.....

3/2/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

DR. GROVES

## 1. PLACE OF DEATH:

County ALLEGANY  
City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 17 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)Street No. 61 GREEN STREET,  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

MRS. AGNES WILSON MILLER

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE WIDOW6. (b) Name of husband or wife WILLIAM MILLER.7. Birth date of deceased (mo., day, yr.) JULY 30, 1860 6. (c) If alive, give age.....years8. AGE: Years Months Days If less than one day  
86 5 26 hrs. min.9. Birthplace MARYLAND  
(Town, county, and state)10. Usual occupation HOUSE WORK

11. Industry or business

12. Name JOHNATHAN WILSON  
13. Birthplace MARYLAND14. Maiden name MATILDA WILLISON15. Birthplace MARYLAND16. Informant MEMORIAL HOSPITAL,Address CUMBERLAND, MD.17. Burial Date thereof Jan. 30, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory I.O.O.F. Cem.Location Near Flintstone, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Jan. 29, 1947 J. P. Traubler, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 26, 1947 at 9:35P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 9, 1947 to Jan. 26, 1947  
and that I last saw him alive on Jan. 26, 1947Immediate cause of death 2 strokes of right  
hypertensive cardio  
vascular renal  
disease  
DURATION 8 yrs  
Due to hypertensive cardio  
vascular renal  
disease  
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following: 9  
Accident, suicide, or homicide accident Date of 1-27-47  
Where did injury occur? Cumberland Allegany, Md.  
(City or town) (county) (state)Injured at home, farm, industry, public place (where?) home  
Means of injury fall (10 ft. high) Injured at work?23. SIGNATURE J. B. Grove M.D. M. D. or other  
Address Cumberland, Md. Date signed 1-27-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 4 1947

BUREAU

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the addition of  
color is shown on  
108 1/15/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00060

Reg. Dist. No. 90

### 1. PLACE OF DEATH:

County Allegheny  
City or town Frostburg, Route 2  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

Francis Ronald Miller

### 3.(b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male W Infant

### 6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 23 - 1946

8. AGE: Years Months Days If less than one day  
4 12 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Frostburg  
(Town, county, and state)

### 10. Usual occupation

### 11. Industry or business

12. Name Thomas Franklin Miller

13. Birthplace Pittsfield, Pa.

14. Maiden name Genevieve C. Spataro

15. Birthplace Frostburg

16. Informant Mrs Spataro

Address Frostburg, Route 2

17. (Burial, cremation, or removal. Which?) Burial Date thereof Sept 6 47  
(month) (day) (year)

Cemetery or crematory St. Michael

Location Frostburg, Md.

18. Funeral director J. J. Dwyer

Address Frostburg

19. 1-6 19 47 Mrs. Nancy N. De  
(Date rec'd by registrar) (month) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 19 47 at 3:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 20 47 to February 4 47 and that I last saw him alive on Jan 2 47 19 47

Immediate cause of death Myocardial Infarction DURATION 6 hours

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Antopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ injured at work? \_\_\_\_\_

23. SIGNATURE W. E. Sattens M.D. M. D. or other \_\_\_\_\_

Address Frostburg, Md. Date signed 1/15/47

RECEIVED

JAN 8 1947

BUREAU

1-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County ALLEGANY  
 City or town FROSTBURG  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 YEARS  
 Hospital, institution, or street address where death occurred:  
77 W. 200 ST.

How long in hospital or institution? 3 wks. in Hosp. 4 wks. at  
77 W. 200 ST.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY  
 City or town FROSTBURG  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 77 W. 200 ST.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

NAVY

## 3. (a) FULL NAME

PAUL ALOYSIUS MONAHAN

## 3. (b) Social Security Number

214-01-0332

4. Sex MALE 5. Color or race White 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife MRS. SARAH MONAHAN

7. Birth date of deceased (mo., day, yr.) JUNE 25-1906 6. (c) If alive, give age 36 years

8. AGE: Years 40 Months 6 Days 0 If less than one day ✓ hrs. ✓ min.

9. Birthplace FROSTBURG - ALLEGANY - MD.  
 (Town, county, and state)

10. Usual occupation BUSINESSMAN11. Industry or business GROCERY

12. Name PATRICK F. MONAHAN  
 13. Birthplace ENGLAND

14. Maiden name ELIZABETH M. DONAHUE  
 15. Birthplace FROSTBURG

16. Informant JOSEPH MONAHAN

Address 77 W. 200 ST. - FROSTBURG, MD.  
 17. BURIAL Date thereof JAN. 27-1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ST. MICHAEL'S CEMETERY  
 Location FROSTBURG - MD.

18. Funeral director JACOB HAFER

Address MAIN ST. - FROSTBURG - MD.  
 19. 1-24 47 W. Nancy N. Roe  
 (Date rec'd by Registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 JANUARY 19 47 at 4:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JANUARY 18 19 47 to JANUARY 24 19 47

and that I last saw him alive on JANUARY 23 19 47

Immediate cause of death ACUTE CARDIAC FAILURE  
due to HYPERTENSION  
SECONDARILY

## DURATION

2 mos.

Due to DIABETES MELLITUS 15 YEARS

Due to CHRONIC GLOMERULONEPHRITIS 1 YEAR

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ✓

Date of op

Autopsy results NOT DONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NONE

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Martin N. Blahut, M.D.

M. D. or other

Address 2 Broadway, Frostburg, Md. Date signed 1/29/47

RECEIVED  
JAN 28 1947  
BUREAU 78

1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 225 Harrison St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Baby Boy Mowery

## 3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

January 14, 1947

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

6 hrs. 15 min.

9. Birthplace

Cumberland, Allegheny, Md  
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER

12. Name

Cyrus Mowery

13. Birthplace

Hyndman, Pa.

14. Maiden name

Minnie Jones

15. Birthplace

Ridgely, W. Va.

16. Informant

Roseella FairallAddress 225 Harrison St. Cumberland

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof January 15, 1947  
(month) (day) (year)

Cemetery or crematory

Hyndman Cemetery

Location

Hyndman, Pa.

18. Funeral director

John J. Hefner

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

19.

Jan 16, 1947  
J. P. Franklin, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 15, 1947 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 14, 1947 to Jan. 15, 1947and that I last saw him alive on Jan. 14, 1947

Immediate cause of death

Monstrosity

DURATION

DISEASE

Heart Lips & Right Palate

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Clayton J. Jones

M. D. or other

Address Cumberland Date signed 1/15/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Please call 65  
when you sign this  
The baby is to be  
buried tomorrow  
at 10:00 A.M.

DR. DAUGHERTY

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00663

## 1. PLACE OF DEATH:

County ALLEGANY  
City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 2 MOS. 17 DAYS2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State MARYLAND County ALLEGANY  
City or town FROSTBURG  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 154 LOO ST.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

SHARON LEE MURPHY4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.)

JULY 23, 1943

8. AGE: Years Months Days It less than one day

362

hrs.

min.

9. Birthplace CUMBERLAND, MARYLAND  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name JOHN A. MURPHY13. Birthplace MARYLANDMOTHER 14. Maiden name SARAH STEELE15. Birthplace MARYLAND16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MARYLAND17. Burial Date thereof Jan 27, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allegheny Cem.Location Frostburg, Md.18. Funeral director J. J. DuvalAddress Frostburg, Md.19. Jan. 25 19 47 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 25 19 47 at 8:40 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Nov. 7 19 46 to Jan 15 19 47and that I last saw him alive on Jan. 25 19 47

Immediate cause of death

Primary carcinoma  
of eye with  
cerebral metastasis

DURATION

approx  
8 mths

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE L. S. Casper M.D. M. D. or otherAddress 104 Kenton Ave. Date signed Jan 25, 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 30 1947  
BUREAU 78

1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumtland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 47 mo 21 days  
 Hospital, institution, or street address where death occurred:  
201 Fifth St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumtland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 201 Fifth St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

William Oscar Murray

## 3. (b) Social Security Number

714-07-6869

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Ira Robertson  
 6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 27 1899  
 8. AGE: Years 47 Months - Days 21 If less than one day ..... hrs. .... min.

9. Birthplace Cumtland Ind.  
 (Town, county, and state)

10. Usual occupation Acute aliph  
 11. Industry or business Belarus Bank

12. Name Daniel Murray  
 13. Birthplace St. Va.

14. Maiden name Mary Hamilton  
 15. Birthplace Ind.

16. Informant Mrs Wm O Murray  
 Address Cumtland

17. Burial Date thereof Jan 23 '47  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Greenmont Cem.  
 Location Cumtland

18. Funeral director Louis Stein Inc  
 Address Cumtland

19. Jan 21 19 47 J. P. Fradette MD  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 19 47 at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 18 19 47 to Jan. 18 19 47 and that I last saw him alive on Jan. 18 19 47

Immediate cause of death Coronary Thrombosis - Sudden

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm O Murray M. D. or other

Address Cumtland Date signed Jan 20/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

10000

RECEIVED

JAN 30 1948

BUREAU V C

2-35

Evidence for the change of  
age is shown on

G 108 2/12/47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00065

9

### 1. PLACE OF DEATH:

County Allegany  
City or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 21 years  
Hospital, institution, or street address where death occurred:  
P. O. Box 700, Frederick  
How long in hospital or institution? 2/2

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Allegany  
City or town Frederick  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. P. O. Box 700, Frederick  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Carl O'Neal

### 3. (b) Social Security Number

218-09-3391

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Elizabeth Porter  
6. (c) If alive, give age 63 years  
7. Birth date of deceased (mo., day, yr.) May 14 1884  
8. AGE: Years 62 Months 10 Days 15 If less than one day  
hrs. min.

9. Birthplace Six Mile Run Pa.  
(Town, county, and state)  
10. Usual occupation Retired miner  
11. Industry or business Coal mines  
12. Name Carl O'Neal  
13. Birthplace Pa.  
14. Maiden name Elaine Parks  
15. Birthplace Pa.

16. Informant Mr. Raymond O'Neal  
Address P. O. Box 700, Frederick  
17. Burial Date thereof 2-1-47  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory Allegany Co. Burial  
Location Frederick, Md.  
18. Funeral director James H. Taylor  
Address Frederick, Md.  
19. 2-1 19 47 Ms. Nancy V. Roe  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1947 at 6:00 P.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 23 1946 to Jan 24 1947  
and that I last saw him alive on Jan 29 1947  
Immediate cause of death Coronary Arteriosclerosis  
DURATION 1 hr  
Due to C.V. Renal disease with heart 1 yr  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE W. G. Gattens M.D.  
Address Frederick, Md. Date signed 1/30/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*Handwritten text, possibly a signature or address, mostly illegible.*

*Handwritten text, possibly a signature or address, mostly illegible.*

RECEIVED  
FEB 3 1907  
BUREAU V.S.

1-35

*Handwritten text at the bottom, mostly illegible.*

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00066

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Allegany Hospital  
 How long in hospital or institution? 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 501 Decatur Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

BENJAMIN ARTHUR POOLE, SR.

## 3. (b) Social Security Number

214-14-7858

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Anna Belle Jones Poole  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) November 8, 1897  
 8. AGE: Years 49 Months 1 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cumberland, Allegany, Maryland  
 (Town, county, and state)  
 10. Usual occupation Door Tender  
 11. Industry or business Fraternal Order of Eagles  
 12. Name Benjamin C. Poole  
 13. Birthplace Cumberland, Md.  
 14. Maiden name Cora Allen  
 15. Birthplace Mercersburg, Pa.

16. Informant Mrs. Anna Belle Poole  
 Address 501 Decatur Street, Cumberland, Md.  
 17. Burial Date thereof Jan. 10, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Hill Crest Burial Park  
Cumberland, Md.  
 Location  
 18. Funeral director William H. Kight  
 Address Cumberland, Md.

19. Jan 9 1947 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1947 at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1946 to Jan 7, 1947  
 and that I last saw him alive on Dec 23, 1946

Immediate cause of death Cerebral Hemorrhage DURATION 2 hours

Due to Hypertension Heart and  
kidney disease years

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. P. Franklin, M.D. M. D. or other \_\_\_\_\_

Address Cumberland, Md. Date signed Jan 8

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 14 1947

BUREAU V S

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00067

9

## 1. PLACE OF DEATH:

County Allegany  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 years  
 Hospital, institution, or street address where death occurred:  
Memorial Hospital  
 How long in hospital or institution? 2 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany  
 City or town 75 E. Main  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Frostburg  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Annie L. Payne

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife George Payne  
 7. Birth date of deceased (mo., day, yr.) Oct. 31 - 1851 6. (c) If alive, give age 95 years  
 8. AGE: Years 95 Months 2 Days 6 If less than one day hrs. min.

9. Birthplace Franklin, Va.  
 (Town, county, and state)

10. Usual occupation Domestic work

## 11. Industry or business

12. Name John W. Miller  
 13. Birthplace Germany, N. Va.  
 14. Maiden name Angelina Fuller  
 15. Birthplace Franklin Co.

16. Informant Mrs. Daisy F. Gurst  
 Address Franklin, Va.

17. Burn Date thereof 1-9-1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. John  
 Location National Highway Franklin

18. Funeral director Wm. H. H. H.  
 Address Frostburg, Md.

19. L-8 19 47 Wm. H. H. H. Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 19 47 at 1200 noon  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 19 46 to Jan 7 19 47  
 and that I last saw her alive on Jan 10 19 47

Immediate cause of death Seriously  
 DURATION years

Due to ✓  
 Due to

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of 1-9-1947  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Wm. H. H. M. D. or other  
 Address Frostburg, Md. Date signed 1-8-47

RECEIVED

JAN 11 1947

BUREAU V S

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 25 Years  
 Hospital, institution, or street address where death occurred:  
609 Frederick St  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Allegany  
 City or town..... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 609 Frederick St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Leela Abbotte Powell

## 3. (b) Social Security Number

None

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married  
 6.(b) Name of husband or wife..... Robert T. Powell  
 6.(c) If alive, give age..... 63 years  
 7. Birth date of deceased (mo., day, yr.)..... May 19 1887  
 8. AGE: Years..... 59 Months..... 7 Days..... 13 It less than one day..... hrs. .... min.

9. Birthplace..... Levels, Hampshire Co, W. Va.  
 (Town, county, and state)  
 10. Usual occupation..... House  
 11. Industry or business.....  
 12. Name..... David M. Dicken  
 13. Birthplace..... Cumberland, Md.  
 14. Maiden name..... Mary Jane Twigg  
 15. Birthplace..... Cumberland, Md.

16. Informant..... Robert T. Powell  
 Address..... 609 Frederick St, Cumberland, Md.  
 17. Burial Date thereof..... 1/5/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Hill Crest Cemetery  
 Location..... Cumberland, Md.  
 18. Funeral director..... William H. Kight  
 Address..... Cumberland, Md.  
 19. Jan. 5 19 47 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 2 19 47 at 10:10 P.  
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 4 19 47 to Jan. 4 19 47 and that I last saw him alive on Jan. 2 19 47  
 Immediate cause of death..... Myocarditis  
 DURATION..... 3 weeks  
 Due to..... Polypenic Myocarditis  
Chronic Nephritis  
 Due to..... Hypertension  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....

23. SIGNATURE..... J. P. Franklin, M.D. M. D. or other.....  
 Address..... 41-9 Ave. H. Cumberland, Md. Date signed..... 1/4/47

RECEIVED

JAN 14 1947

BUREAU V 8

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits  
FAG

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Lifetime  
Hospital, institution, or street address where death occurred:  
251 Williams St.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 251 Williams St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

## 3. (a) FULL NAME

Joseph Francis Pratt

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Agnes C. Pratt  
6.(c) If alive, give age 50 years  
7. Birth date of deceased (mo., day, yr.) June 25, 1885  
8. AGE: Years 61 Months 6 Days 20 If less than one day  
hrs. min.

9. Birthplace Mt. Savage, Allegheny, Md.  
(Town, county, and state)  
10. Usual occupation Grocer  
11. Industry or business Own business  
FATHER 12. Name George Pratt  
13. Birthplace Mt. Savage, Md.  
MOTHER 14. Maiden name Ellen Jackson  
15. Birthplace Mt. Savage

16. Informant Georgia Moss  
Address 121 Baltimore St. Cumberland  
17. Tomb Burial Date thereof January 18, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory St. Patrick's Cemetery  
Location Cumberland, Md.  
18. Funeral director John J. Heffer  
Address Jan 17 47 J. O. Ranklin  
19. (Date rec'd by registrar) 19 47 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 15, 1947 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10, 1947 to Jan 15, 1947  
and that I last saw him alive on Jan 13, 1947

Immediate cause of death Cerebral Thrombosis  
DURATION 5 years

Due to Hypertension Heart and disease

Due to  
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE F. Allen E. Kennedy  
M. D. or other  
Address Cumberland, Md. Date signed Jan 16, 47

RECEIVED

JAN 21 1947

BUREAU V S

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 000708

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Marionburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 yrs  
 Hospital, institution, or street address where death occurred:  
Orange Ave  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegheny  
 City or town Marionburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Orange Ave  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war First World War

## 3. (a) FULL NAME

Charles P. Reichelt

## 3. (b) Social Security Number

216-05-5889

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1896 6. (c) If alive, give age 47 years

8. AGE: Years 50 Months - Days 18 If less than one day hrs. min.

9. Birthplace Marionburg, Allegheny Co., Md  
 (Town, county, and state)

10. Usual occupation Silk Mill Worker

11. Industry or business General Pestle Mills

12. Name Adolph Reichelt

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant August Reichelt

Address Marionburg, Md

17. Funeral Date thereof Jan. 14, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Marionburg, Md

18. Funeral director W. E. Eichhorn

Address Marionburg, Md

19. Jan 14 47 Josephine M. Coal  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11, 1947 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 24, 1946 to Jan. 11, 1947

and that I last saw him alive on Jan. 11, 1947

Immediate cause of death cardiac failure due to  
valvular dysfunction

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

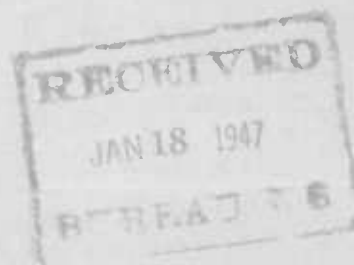
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

3. SIGNATURE Henry G. Hodgeson M. D. or other

Address Marionburg, Md Date signed Jan 13 47



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Mt. Savage  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

EMMA ELIZABETH REYNOLDS

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife Patrick F. Reynolds

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) October 4, 18778. AGE: Years Months Days If less than one day  
69 3 23 hrs. min.9. Birthplace Mt. Savage, Allegany County, Maryland  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name Stephen Porter13. Birthplace Mt. Savage, Maryland14. Maiden name Elizabeth Woods15. Birthplace Virginia16. Informant Mrs. James GrahamAddress Mt. Savage, Md.17. Burial Date thereof Jan. 30, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Patrick's Cem.Location Mt. Savage, Md.18. Funeral director J. J. DurstAddress Brookburg, Md.19. Jan 28, 1947 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27, 1947 at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 17, 1947 to Jan 27, 1947  
and that I last saw him alive on Jan 27, 1947

Immediate cause of death

Myocardial infarction  
ShockDue to Myocardial infarctionMyocardial infarctionDue to Myocardial infarctionMyocardial infarction

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Myocardial infarction  
Gale Bladder Date of op. Jan 18, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

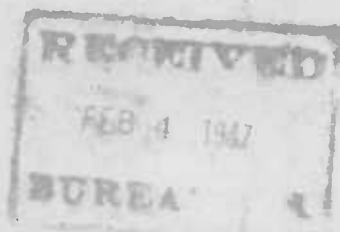
J. P. Franklin, M.D. M. D. or otherAddress \_\_\_\_\_ Date signed Jan 28, 1947

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ✓

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County Allegany  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Clara Mae Richardson

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Joseph Richardson

7. Birth date of deceased (mo., day, yr.)

July 6, 1868

6. (c) If alive, give age..... years

8. AGE:

Years 78

Months 6

Days 11

If less than one day

hrs. .... min.

9. Birthplace

Vale Summit Md.  
 (Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

MOTHER

FATHER

MOTHER

FATHER

MOTHER

FATHER

MOTHER

FATHER

MOTHER

FATHER

MOTHER

FATHER

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FATHER

MOTHER

FATHER

MOTHER

12. Name Nelson Duckworth13. Birthplace Moscow, Md.14. Maiden name Mary Youker15. Birthplace Germany16. Informant Edna M. LeeAddress 143 Maple St. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?)

Allegany

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

12. Name Nelson Duckworth13. Birthplace Moscow, Md.14. Maiden name Mary Youker15. Birthplace Germany16. Informant Edna M. LeeAddress 143 Maple St. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?)

Allegany

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

12. Name Nelson Duckworth13. Birthplace Moscow, Md.14. Maiden name Mary Youker15. Birthplace Germany16. Informant Edna M. LeeAddress 143 Maple St. Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?)

Allegany

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

Frostburg

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Washington St.  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1947, at 2:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1948 1947, to 1947

and that I last saw him alive on Jan 18 1947

Immediate cause of death

Coronary thrombosis

DURATION

Sudden

Due to

Hypertension

Due to

Hypertension

Other conditions

Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations

Hypertension

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. M. C. Lee

M. D. or other

Address Frostburg Md.Date signed 1-18-4719. 1-20 1947 Registrar

Miss Nancy N. Roe

Registrar

RECEIVED  
JAN 23 1947  
BUREAU V B

1-55

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH: *Allegany*  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *74 years*  
Hospital, institution, or street address where death occurred: *Robbins Street*  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....*Maryland* County.....*Allegany*  
City or town.....*Hammarist Md*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....*Robbins Street*  
(If rural, give LOCATION).....

2.(a) If veteran, name war.....

3. (a) FULL NAME *Hannah Lynch Richmond*

3. (b) Social Security Number.....

4. Sex *Female* 5. Color or race *White* 6.(b) Single, married, widowed, or divorced *Widowed*

6.(b) Name of husband or wife *Wm. C. Richmond*

7. Birth date of deceased (mo., day, yr.) *Dec. 7, 1864* 6.(c) If alive, give age..... years

8. AGE: Years *82* Months *1* Days *12* If less than one day..... hrs. .... min.

9. Birthplace.....  
(Town, county, and state) *Illinois*

10. Usual occupation *Housework*

11. Industry or business *Own home*

FATHER 12. Name.....*John Lynch*  
13. Birthplace.....*Groveton Md*

MOTHER 14. Maiden name.....*Isabel Richmond*  
15. Birthplace.....*Scotland*

16. Informant.....*James Richmond*  
Address.....*Hammarist Md*

17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof.....*Jan. 22, 1947*  
(month) (day) (year)  
Cemetery or crematory.....*Oak Hill Cemetery*  
Location.....*Hammarist Md*

18. Funeral director.....*Wm. Eichhorn*  
Address.....*Hammarist Md*

19. *Jan 22*.....*1947* *Janette M. Neal*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Jan. 19*.....*1947* at.....*11* P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*November*.....*1946* to.....*Jan 19*.....*1947*  
and that I last saw him alive on.....*January 19*.....*1947*

Immediate cause of death.....*Cerebral Hemorrhage*

Due to.....*arterio Sclerosis*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

## DURATION

*2 day**2 yr*

Major findings of operations..... Date of op.....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?.....  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?).....  
Means of injury..... Injured at work?.....

23. SIGNATURE.....*E. Don Johnson*  
M. D. or other  
Address.....*Hammarist* Date signed.....*Jan. 21-1947*

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JAN 25 1947  
BUREAU V.S.

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

### 1. PLACE OF DEATH:

County Allegany  
City or town Conacong, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Boston Terrace  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Conacong, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Boston Terrace  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary Anne Boston Richmond

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife John Richmond

7. Birth date of deceased (mo., day, yr.) April 29, 1859 6.(c) If alive, give age 87 years

8. AGE: Years 87 Months 9 Days 1 If less than one day  
hrs. min.

9. Birthplace Conacong, Allegany Co., Md.  
(Town, county and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Adam Boston

13. Birthplace England

14. Maiden name Elizabeth Elliott

15. Birthplace England

16. Informant Mrs. Bessie Gaudis

Address Wilmington, Delaware

17. Burial, cremation, or removal, Which? Burial Date thereof Feb. 1, 1947  
(month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Conacong, Md.

18. Funeral director M. G. Richmond

Address Conacong, Md.

19. Feb. 1, 1947 Registrar Janette M. Paul

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 1947, at 11:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 to Jan 30 1947  
and that I last saw him alive on Jan 29 1947

Immediate cause of death chronic nephritis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

Means of Injury

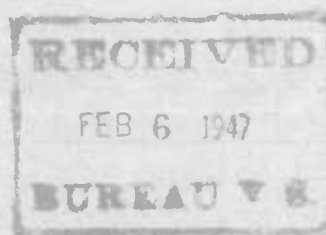
23. SIGNATURE Henry M. Hodgson M.D.

Address Conacong, Md. Date signed Jan 31, 1947

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

DR. MATHEWS

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

000754

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 4 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. (Transient)  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

THOMAS ROBERTSON

## 3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb 28, 18756. (c) If alive, give age. 4 years8. AGE: Year 71 Months 10 Days 3 If less than one day  
hrs. min.9. Birthplace Ocean, Allegany Co., W. Va.  
(Town, county, and state)10. Usual occupation Coal Miner11. Industry or business Consol. Coal Co.12. Name Joseph H. Robertson13. Birthplace Scotland14. Maiden name Jane Thomas15. Birthplace Scotland16. Informant Benjamin ThomasAddress Pittsburg, Pa.17. Burial Date thereof Jan. 6, 1947  
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory Allegany CemeteryLocation Worthing, Ind.18. Funeral director M. J. SchickhornAddress Zenacoring, Md.19. Jan. 6, 1947 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1947 at 9:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1947 to Jan 4 1947and that I last saw him alive on Jan 4 1947Immediate cause of death Chronic Myocarditis DURATION

Due to

Due to

Other conditions Bronchial Asthma

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. A. Mathews, Jr. M. D. or otherAddress 49 Greene St. Date signed 1-4-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

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JAN 14 1947

BUREAU

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Westernport, rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 4 years  
 Hospital, institution, or street address where death occurred:  
2 miles east of Westernport  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Allegany  
 City or town..... Westernport, rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 2 miles east of Westernport  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Chester Arthur Robison

## 3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widower

6. (b) Name of husband or wife..... Amelia Bryant Robison 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... October 1, 1868

8. AGE: Years..... 78 Months..... 3 Days..... 0 If less than one day..... hrs. .... min.

9. Birthplace..... Cumberland, Allegany, Maryland  
 (Town, county, and state)

10. Usual occupation..... Farmer

## 11. Industry or business

FATHER 12. Name..... Levi Robison  
 13. Birthplace..... Cumberland, Maryland

MOTHER 14. Maiden name.....  
 15. Birthplace.....

16. Informant..... Walter Ross  
 Address..... Westernport, Maryland

17. Burial..... Burial Date thereof..... Jan 4, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Philos Cemetery  
Westernport, Maryland  
 Location.....

18. Funeral director..... Ellsworth S. Boal  
 Address..... Westernport, Maryland

19. (Date rec'd by registrar)..... Jan 3 1947 Registrar..... W. H. Jenkins

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 1, 1947 19..... 9:00p M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1st to Jan 1st 1947

and that I last saw him..... alive on Dec 24 1946

Immediate cause of death..... Myocardial Infarction

Due to..... Coronary heart failure

Other conditions..... Nephritis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... W. H. Jenkins M. D. or other

Address..... Westernport, W. Va. Date signed..... 1/2/47

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JAN 4 1947  
BUREAU V.B.

1-35

HODGES

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

00077

## CERTIFICATE OF DEATH

Reg. Dist. No.

A

## 1. PLACE OF DEATH:

County... Allegany  
 City or town... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 14 Minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... AlleganyCity or town... Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 724 Cephart Drive  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Baby Boy Roby

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

January 19, 1947

8. AGE:

Years

Months

Days

If less than one day

hrs.

14 min.9. Birthplace... Cumberland, Allegany, Maryland  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER  
MOTHER12. Name Frederic Roby13. Birthplace Maryland14. Maiden name Kienhoffer, Loretta15. Birthplace Maryland16. Informant Memorial HospitalAddress Cumberland, Maryland17. Cremated  
(Burial, cremation, or removal, which?)

Date thereof

Jan. 22, 1947

Cemetery or crematory

Location

18. Funeral director

Address

19. Jan. 21 19 47  
(Date rec'd by registrar)Joe O. Franklin MD  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 19 47 at 5:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 19 19 47 to Jan. 19 19 47  
and that I last saw him in alive on Jan. 19 19 47

Immediate cause of death

Prematurity

DURATION

5 m.

Due to

Due to

Other conditions

(Include pregnancy within 9 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 1/19/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 30 1947

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2-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

### 1. PLACE OF DEATH:

County Allegany  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 11 days  
Hospital, institution, or street address where death occurred:  
Miners' Hospital  
How long in hospital or institution? 11 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Frostburg, Route B  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Baby

### 3. (b) Social Security Number

Rowan

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Single

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) January 11 1947  
6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 17 hrs. \_\_\_\_\_ min.  
If less than one day

9. Birthplace Frostburg Allegany, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Albert Spataro

13. Birthplace Morantown Md.

14. Maiden name Betty Rowan

15. Birthplace Londoning Md.

18. Informant Betty Rowan

Address Frostburg Md. Route 2

17. Burial Burial Date thereof Jan. 23, 1947  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg Md.

18. Funeral director J. J. Durst

Address Frostburg Md.

19. 1-22 47 See Nancy A. Roe  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1947 at 8:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 11 1947 to Jan 21 1947  
and that I last saw him/her alive on Jan 21 1947

Immediate cause of death Premature  
WT 3'2"

### DURATION

10 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. G. Gattens M.D.  
M. D. or other

Address Frostburg Md. Date signed 1/22/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00078

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JAN 25 1947  
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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 22 Years  
 Hospital, institution, or street address where death occurred:  
222 Beall St  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany  
 City or town..... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 222 Beall St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Lee Edward Ruddle

## 3. (b) Social Security Number

214-07-0354

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married  
 6.(b) Name of husband or wife..... wessie Athey Ruddle  
 6.(c) If alive, give age..... 47 years  
 7. Birth date of deceased (mo., day, yr.)..... May 16 1886  
 8. AGE: Years..... 60 Months..... 8 Days..... 13 If less than one day..... hrs. .... min.

9. Birthplace..... Ruddle, Pennelton Co, West Virginia  
 (Town, county, and state)

10. Usual occupation..... Cafeteria

11. Industry or business..... Kelly Springfield Tire Co

MOTHER FATHER  
 12. Name..... Edward D. Ruddle  
 13. Birthplace..... Franklin W. Va.  
 14. Maiden name..... Dorothy Puffenbarger  
 15. Birthplace..... Franklin, W. Va.

16. Informant..... Mrs. Lee Ruddle  
 Address..... 222 Beall St, Cumberland, Md.

17. Burial..... Date thereof..... Feb 1, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Philos Cemetery  
 Location..... Westernport, Md.

18. Funeral director..... William H. Knight  
 Address..... Cumberland, Md.

19. Feb. 1, 1947 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 29 1947 at 1:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 27 1947 to Jan 29 1947  
 and that I last saw him alive on Jan 29 1947

Immediate cause of death.....  
Cerebral Hemorrhage  
Chronic Hypertension  
Arteriosclerosis

## DURATION

2 days  
10 hrs  
10 min

Due to.....  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

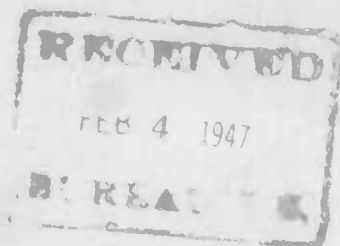
Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....

23. SIGNATURE.....  
J. P. Franklin, M.D. M. D. or other  
 Address..... 26 Queen St. Cumberland Md Date signed..... 1/30/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 49-10-1

Hospital, institution, or street address where death occurred:

323 Columbia St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny  
City or town Cumberland Ind  
(If outside city or town limits, write RURAL and give nearest town)Street 323 Columbia St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Leah Pancy Schneider

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Wm A Schneider

7. Birth date of

deceased (mo., day, yr.)

March 13 1897

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

49101

hrs.

min.

9. Birthplace

Cumberland Ind.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Joseph E. Smith

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 21 1947  
BUREAU VS

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00081

90

## 1. PLACE OF DEATH:

County Allegany  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 months  
 Hospital, institution, or street address where death occurred:  
Miners' Hospital - Frostburg, Md.  
 How long in hospital or institution? 6 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State MARYLAND County ALLEGANY  
 City or town SAVALE  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war NONE

## 3. (a) FULL NAME

HARRY SCHUMANN

## 3. (b) Social Security Number

## 4. Sex

MALE

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

July 25 - 1946

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

060✓ hrs.✓ min.

## 9. Birthplace

FROSTBURG - MD.  
(Town, county, and state)

## 10. Usual occupation

✓ NONE

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

RICHARD SCHUMAN

## 13. Birthplace

Chicago Ill.

## 14. Maiden name

MARGARET MARYLAND ORT

## 15. Birthplace

MIDLAND MD.

## 16. Informant

HOSPITAL RECORDS

## Address

Frostburg - Md.

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

Jan 26 - 1947  
(month) (day) (year)

## Cemetery or crematory

3 in Memorial  
Cumberland, Md.

## Location

H. Wayne George

## 16. Funeral director

## Address

Cumberland, Md.

## 19.

(Date rec'd by registrar)

19

47 Mrs. Nancy H. Roe

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 January 19 47, at 6:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
15 January 19 47 to 24 January 19 47  
 and that I last saw him alive on 24 January 19 47

## Immediate cause of death

Cryptosporidiosis  
fetalis ??

## Due to

??

## Due to

## Other conditions

NONE - ?

(Include pregnancy within 8 months of death)

## Major findings of operations

NONE

## Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

NONE

Accident, suicide, or homicide

## Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

## 23. SIGNATURE

Madeline Rothford  
M. D. or otherAddress 2 Broadway - FrostburgDate signed 1/24/47

STATE OF TEXAS

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JAN 28 1947

BUREAU

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 10 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 328 Virginia Ave  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Kenneth Allen Shaffer

## 3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

September 12 1946

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

# 4 19

hrs. min.

9. Birthplace

CumberlandMd.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name A. O. Shaffer13. Birthplace Pennsylvania

MOTHER

14. Maiden name Lucy Bryant15. Birthplace Pennsylvania

16. Informant

A. O. Shaffer

Address

Cumberland Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/3/47  
(mo. day) (year)Cemetery or crematory Hyndman, Pa.Location Hyndman, Pa.H. H. Zeigler

18. Funeral director

Address

Hyndman, Pa19. Feb 4

(Date rec'd by registrar)

19 47J. P. Frankel, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Jan 19 47 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

31 Jan 19 47 to 47and that I last saw him alive on 31 Jan 19 47

Immediate cause of death

Verus Pneumonia

DURATION

Due to

Due to

Other conditions

None observed

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

L. S. Cooper M.D.

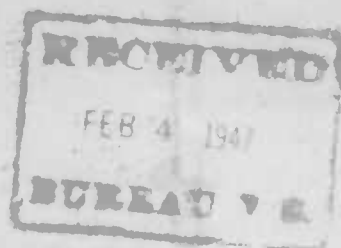
M. D. or other

Address

Memorial Hosp.

Date signed

1 Feb 47



1-35

Outside of  
City Limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170

00083

## CERTIFICATE OF DEATH

Reg. Dist. No.

42

## 1. PLACE OF DEATH:

County Allegany  
City or town Rural) in route from Wellersburg Pa.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

in route from Wellersburg Pa. to  
Allegany Hospital Cumberland Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County Bedford  
City or town Rural) Fairhope) Hyndman Pa. R.D.  
(If outside city or town limits, write RURAL and give nearest town)Street No. Bedford Co.  
(If rural, give LOCATION)2. (a) If veteran, name war 723\*07\*\*8016

## 3. (a) FULL NAME

Walter R. Shaffer

## 3. (b) Social Security Number

723-0749016

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of  
deceased (mo., day, yr.)December 6, 1929

8. AGE: Years Months Days If less than one day

18 17021

hrs.

min.

9. Birthplace Hyndman, Bedford, Pa.  
(Town, county, and state)10. Usual occupation Truck helper

11. Industry or business

12. Name Nobel Shaffer13. Birthplace Bedford, Pa.14. Maiden name Jane Smith15. Birthplace Lawton, Hyndman, Pa.16. Informant Nobel ShafferAddress Rural Hyndman, Penna.17. Burial Date thereof Jan. 6, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory HyndmanLocation Hyndman, Pa.18. Funeral director H. H. LeiglerAddress Hyndman, Pa.19. Jan 6 47 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 19 47, at 12.20 P. about

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him in Dead Jan. 3 19 47

Immediate cause of death

Fractured cervical vertebrae aboutFractured pelvis & abdominal 20Due to hemorrhage minutesDue to sick, sitting on floor of  
coal truck with feet on running  
board, fell from truck and was  
run over with rear wheels of truck.  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of pp.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

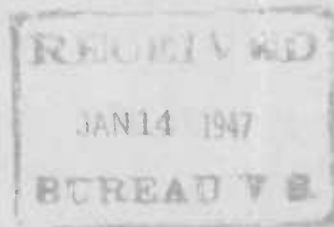
Accident, suicide, or homicide accident Date of 1-3-47Where did injury occur? near Wellersburg Bedford, Pa.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) in route to  
Allegany HospitalMeans of injury as above Injured at work yes23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.  
M. D. or otherAddress Cumberland Md Date signed 1-3-1947

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

R. WILLIAMS

93C

00084

Reg. Dist. No.

4

## 1. PLACE OF DEATH:

County ALLEGANY  
 City or town CIMBERLAND, MARYLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 Years  
 Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
 How long in hospital or institution? FOUR DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY  
 City or town CIMBERLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 8 OFFUTT ST  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3.(a) FULL NAME

Nola Carolee Sharon

## 3.(b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED  
 6.(b) Name of husband or wife EDGAR SHARON  
 6.(c) If alive, give age 42 years  
 7. Birth date of deceased (mo., day, yr.) OCT. 10, 1909 OCT. 10, 1908  
 8. AGE: Years 38 Months 3 Days 11 hrs. min.

9. Birthplace W. VA  
 (Town, county, and state)  
 10. Usual occupation HOUSE WIFE  
 11. Industry or business  
 12. Name CHARLES KISSNER JR.  
 13. Birthplace Morgantown, W. Va.  
 14. Maiden name SHIRES  
 15. Birthplace Great Cacapon, W. Va.

16. Informant MEMORIAL HOSPITAL  
 Address CIMBERLAND, MD  
 17. Burial Date thereof January 24, 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Great Cacapon Cemetery  
 Location Great Cacapon, W. Va.  
 18. Funeral director John A. Hofer  
 Address Cimberland, Md.  
 19. Jan. 24, 1947 J. P. Franklin, M. D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 21, 1947 19 47 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18, 47 19 to Jan 21, 47 19  
 and that I last saw h. 2 alive on Jan 21, 47 19

Immediate cause of death Rheumatic C.V.D.  
 DURATION

Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op  
 Autopsy results Rheumatic Heart - Corroding  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE J. P. Franklin, M. D. M. D. or other  
 Address Cimberland, Md. Date signed 1/24/47

RECEIVED

JAN 30 1947

BUREAU 8

2-35

Within corporate limits  
Evidence for changes made is shown  
on G 109 3/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany  
City or town Cumberland Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 Days  
Hospital, institution, or street address where death occurred:  
Memorial Hospital  
How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State W. Va. County Morgan  
City or town Paw Paw  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war World War 2.

3. (a) FULL NAME

Alfred Sirbaugh ALFRED PRESTON SIRBAUGH

3. (b) Social Security Number

232-26-5376

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Madeline Louise Lizzie Sirbaugh  
7. Birth date of deceased (mo., day, yr.) July 26, 1913/ 1914 6. (c) If alive, give age 24 years  
8. AGE: Years 32 Months 5 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cumberland, Md. West Virginia  
(Town, county, and state)

10. Usual occupation Orchard Worker

11. Industry or business \_\_\_\_\_

FATHER 12. Name Jacob Frank J. Sirbaugh  
13. Birthplace Virginia

MOTHER 14. Maiden name Myrtle Sirbaugh Bailey  
15. Birthplace Luray, Virginia

16. Informant W. D. Parks  
Address Berkley Springs, W. Va.

17. Burial Burial Date thereof Jan. 10, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Woodrow Cemetery  
Woodrow, W. Va.  
Location \_\_\_\_\_

18. Funeral director XXXXXXXXXXXX W. D. Parks  
Address Berkley Springs, W. Va.

19. Jan. 9, 47 J. P. Traubli, M.D.  
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6 19 47 at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
and that I last saw him Dead Jan. 6 19 47  
alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death intercranial hemorrhage DURATION about 2 days  
Due to fracture of the skull

Due to a fall accidentally from a porch

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide accident Date of 1-4-47  
Where did injury occur? Cumberland Allegany Md  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) 210 Laing Ave  
Means of injury as above Injured at work? no

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.  
M. D. or other \_\_\_\_\_  
Address Cumberland Md Date signed 1-7-1947

MARGIN RESERVED FOR BINDING

VS A15

9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 14 1947

BUREAU V &

1-35

DR. HODGES

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00086

40

## 1. PLACE OF DEATH:

County.....ALLEGANY

City or town.....MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 4 HRS. 35 MIN.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....WEST VIRGINIA County.....MINERAL

City or town.....PIEDMONT  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## 3. (a) FULL NAME

SMITH, BABY BOY

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

INFANT

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.) JANUARY 27, 1947

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

NEWBORN

4

hrs.

35 min.

9. Birthplace.....CUMBERLAND, MARYLAND  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name.....SMITH, ALTON

13. Birthplace.....WEST VIRGINIA

MOTHER

14. Maiden name.....HASLAKER, LEANNA

15. Birthplace.....MARYLAND

16. Informant.....MEMORIAL HOSPITAL

Address.....CUMBERLAND, MARYLAND

17. Cremation

Date thereof.....

1/27/47

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....MEMORIAL HOSPITAL

Location.....CUMBERLAND, MD.

18. Funeral director

Same as above

Address

19. (Date rec'd by registrar)

19

47

J. P. Franklin, M.D.  
Registrar

23. SIGNATURE

Address

Cumberland, Md.  
Date signed 1/27/47

M. D. or other

Date signed

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....JANUARY 27, 1947, at 6:15 P

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

1/27, 1947, to 1/27, 1947, and that I last saw him alive on 1/27/47

Immediate cause of death

Prematurity - 6 months gestation  
Lactemia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

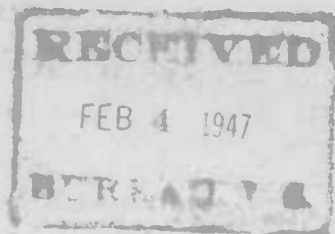
Injured at work?

W. P. Hodges, M.D.

MARGIN RESERVED FOR BINDING

VS A15 6-45:15M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131

00087

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

## 1. PLACE OF DEATH:

County..... Allegany  
 City or town..... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 5 Weeks  
 Hospital, institution, or street address where death occurred:  
Allegany Hospital  
 How long in hospital or institution?..... 5 Weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Allegany  
 City or town..... Near Flintstone, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... (Green Ridge) Flintstone  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Bessie Smith

## 3. (b) Social Security Number

None

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married  
 6. (b) Name of husband or wife..... Thaddeus Smith  
 6. (c) If alive, give age..... 67 years  
 7. Birth date of deceased (mo., day, yr.)..... September 7 1892  
 8. AGE: Years..... 54 Months..... 4 Days..... 1 If less than one day..... hrs. .... min.

9. Birthplace..... Piney Grove, Allegany, Maryland  
 (Town, county, and state)

10. Usual occupation..... House

11. Industry or business.....

FATHER 12. Name..... George Nolan

13. Birthplace..... Piney Grove, Md.

MOTHER 14. Maiden name..... Susan Smith

15. Birthplace..... Piney Grove, Md.

16. Informant..... Thaddeus Smith

Address..... R.F.D. Flintstone, Md.

17. Burial..... Burial Date thereof..... January 12/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Fairview Cemetery

Location..... Englesmith, Pa.

18. Funeral director..... William H. Kight

Address..... Cumberland, Md.

19. Jan 10 19 47 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 8 19 47 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
12/17/46 19 46 to 1/8/47 19 47  
 and that I last saw her alive on 1/8/47 19 47

Immediate cause of death..... 1) uremia  
2) chronic nephritis  
3) thrombosis of kidneys  
4) pneumonia

Due to.....  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... John N. Rozum MD  
 Address..... Cumberland, Md. Date signed..... 1/8/47  
 M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 14 1947

BUREAU V 6

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

DR. WILSON

## 1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

1 DAY

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County MineralCity or town PIEDMONT  
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 DUNDEE ST.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

MR. CHARLESH. SMITH

## 3. (b) Social Security Number

705-07-6550

## 4. Sex

MALE

## 5. Color or race

WHITE

## 6. (a) Single, married, widowed, or divorced

WIDOWED

## 6. (b) Name of husband or wife

THERESA INSKEEP

## 7. Birth date of deceased (mo., day, yr.)

11/28/82

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

64124

hrs.

min.

## 9. Birthplace

WEST VIRGINIA

(Town, county, and state)

## 10. Usual occupation

ENGINEERB. & O.

## 11. Industry or business

FATHER

## 12. Name

MARCELLUS SMITH

## 13. Birthplace

WEST VIRGINIA

MOTHER

## 14. Maiden name

MARJORIE KELLEY

## 15. Birthplace

WEST VIRGINIA

## 16. Informant

MEMORIAL HOSPITAL

## Address

CUMBERLAND, MD.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Jan. 24, 1947  
(month) (day) (year)

## Cemetery or crematory

Philos Cem.

## Location

Westonport, Md.

## 18. Funeral director

W. Harold Trelock

## Address

Piedmont, W. Va.

## 19. Jan. 24, 1947

(Date rec'd by registrar)

19. 47

J. P. Franklin, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 22 19 47 at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 21, 1947 to Jan. 23, 1947  
and that I last saw him alive on Jan. 21, 1947

Immediate cause of death

Shock

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Jan. 21, 1947Where did injury occur? near Oak Camp, Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) RailroadMeans of injury scalp Injured at work? yes

23. SIGNATURE

F. M. Wilson, M.D.  
M. D. or otherAddress Cumberland, Md. Date signed 1-23-47

RECEIVED

JAN 30 1947

BUREAU 78

2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

168

00089

## CERTIFICATE OF DEATH

Reg. Dist. No.

40

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Mineral  
 City or town Ridgely  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6 John St.  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Lawrence Fred Smith

## 3. (b) Social Security Number

705-10-8533

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife Virginia Welfong7. Birth date of deceased (mo., day, yr.) December 3, 19048. AGE: Years Months Days If less than one day  
42 1 18 hrs. min.9. Birthplace Elkins Randolph Co. W. Va.  
(Town, county, and state)10. Usual occupation Brake Conductor11. Industry or business Wp Md. R. R. Co.12. Name Samuel Smith13. Birthplace West Virginia14. Maiden name Savannah Lee15. Birthplace West Virginia16. Informant Mrs. Lawrence SmithAddress 6 John St., Ridgely, W. Va.17. Burial Date thereat Feb 4, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Zion Memorial CemLocation Cumberland, Md.18. Funeral director Chas. L. GeorgeAddress Cumberland, Md.19. Feb 1, 1947 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 19 47 at 8:03 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him Dead Jan. 31 19 47

Immediate cause of death

Meningitis, following fracture 5

of the skull, a small piece of days

Due to skull bone had punctured

dura.Due to History Hit over left eyewith a coffee pot, duringargument. 1-26-47

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

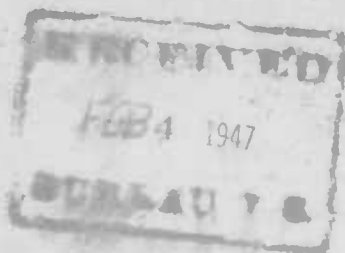
Accident, suicide, or homicide homicide Date of 1.26.47Where did injury occur? Ridgely Mineral W. Va.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury as above Injured at work? noPhysician's Signature Allegany Co.23. SIGNATURE H. V. Deming, M.D. M. D. or otherAddress Cumberland Md Date signed Feb 1-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

### 1. PLACE OF DEATH:

County Alleg.  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos.

Hospital, institution, or street address where death occurred:  
Miners Hospital

How long in hospital or institution? 4 mos.

### 3. (a) FULL NAME

Beatrice Gay  
Beatrice Girl Titer

4. Sex Female 5. Color or race W 6. (a) Single, married, widowed, or divorced —

6. (b) Name of husband or wife In

7. Birth date of deceased (mo., day, yr.) January 16, 1947

8. AGE: Years 4 Months — Days — If less than one day 4 hrs. — min.

9. Birthplace Frostburg, Md.  
(Town, county, and state)

10. Usual occupation X

11. Industry or business X

FATHER 12. Name Leon Titer

13. Birthplace Parsons W. Va.

MOTHER 14. Maiden name Helen A. Combs

15. Birthplace Long, Md.

16. Informant Mrs. Leon Titer

Address Corriganville, Md.

17. Burial — Date thereof 1-18-1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Jacob Draper

Address Frostburg, Md.

19. 1-17 19. 47 Mrs. Nancy H. Roe  
(Date rec'd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Alleg.

City or town Corriganville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. —  
(If rural, give LOCATION)

2. (a) If veteran, name war —

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 16, 1947, at 5 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 16, 1947, to January 16, 1947

and that I last saw her alive on January 16, 1947

Immediate cause of death Premature birth (5 mos)

Due to —

Due to —

Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

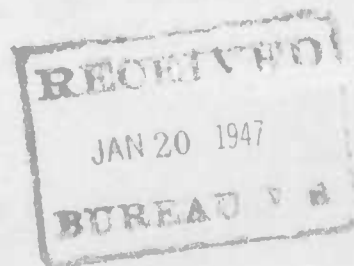
23. SIGNATURE H. C. Siehl, M.D.

Address Frostburg, Md. Date signed 1/17/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00091

94a

40

### 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Embassy Theater 49 Baltimore St.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 132 N. Center St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

WILLIAM  
Charles Thomas

### 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Lucy Ellen Russell

7. Birth date of deceased (mo., day, yr.)

April 7, 1869

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

77

9

-

hrs.

min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

Lab. w.

11. Industry or business

general

FATHER

12. Name

Thomas Thomas

13. Birthplace

Ind.

MOTHER

14. Maiden name

Ellen Brown

15. Birthplace

16. Informant

Charles Thomas

Address

901-10th St. S.E. Wash. D. C.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Jan 10 '47  
(month) (day) (year)

Cemetery or crematory

Rose Hill Cem.

Location

Cumberland

18. Funeral director

Louis Stein Inc.

Address

Cumberland

19. (Date rec'd by registrar)

Jan 10, 1947

J. P. Franklin, M.D.  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7 19 47 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... 10..... 19.....

and that I last saw him Dead Jan. 7 19 47

Immediate cause of death

Coronary occlusion

DURATION

at once

Due to Arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner Allegany Co.

23. SIGNATURE

H.V. Deming M.D. K.K. Deming M.D.

M. D. or other

Address Cumberland Md.

Date signed 1-9-1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 14 1947

BUREAU V S

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 yearsHospital, institution, or street address where death occurred:  
506 Eastern Ave.

How long in hospital or institution?

## 3. (a) FULL NAME

Frank Edward Thompson

## 3. (b) Social Security Number

217-10-6050

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Lulu Heffer Thompson7. Birth date of deceased (mo., day, yr.) March 28, 1883

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

63911

hrs.

min.

9. Birthplace Jonesboro, Tennessee  
(Town, county, and state)10. Usual occupation Retired Electrician11. Industry or business Colonore Corp. of America12. Name Albert Thompson13. Birthplace Tenn14. Maiden name Jarah E. Whitmore15. Birthplace Tenn16. Informant Mrs. Lulu ThompsonAddress 506 Eastern Ave, Cumberland, Md.17. Burial Date thereof January 12, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest CemeteryLocation Cumberland, Md.18. Funeral director John J. HaterAddress Cumberland, Md.19. Jan 12, 1947 J. P. Frankish, M.D.  
(Date rec'd by registrar) Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State Maryland County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 506 Eastern Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-3-1945 to 1-9-1947  
and that I last saw him alive on 1-2-1947

Immediate cause of death

cause of the right maxillary sinus

DURATION

One year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

cause of right maxillary sinusDate of op. 4-10-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Hines M.D.

M. D. or other

Address 58 Green St. Date signed 1-10-47

RECEIVED  
JAN 21 1947  
BUREAU V E

2-35

170 hours

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

834

00093

CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH:

County... Allegheny  
City or town... Chamberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 12 1/2 hrs  
Hospital, institution, or street address where death occurred... Memorial Hospital  
How long in hospital or institution? 12 1/2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... W. Va. County... Hampshire  
City or town... Romney  
(If outside city or town limits, write RURAL and give nearest town)  
Street No... River Route  
(If rural, give LOCATION)  
2.(a) If veteran, name war... ✓

3. (a) FULL NAME

Minnie Belle Timbrook

3. (b) Social Security Number

None

4. Sex... Female 5. Color or race... White 6.(a) Single, married, widowed, or divorced... Married  
6.(b) Name of husband or wife... Philip H. Timbrook  
7. Birth date of deceased (mo., day, yr.)... Feb 11, 1885 6.(c) If alive, give age... 74 years

8. AGE: Years... 61 Months... 11 Days... 19 hrs... min...  
It less than one day

9. Birthplace... Romney, Hampshire Co. W. Va.  
(Town, county, and state)

10. Usual occupation... Housework

11. Industry or business... at Home

12. Name... David Jay

13. Birthplace... Romney W. Va.

14. Maiden name... Catherine Holt

15. Birthplace... Hampshire Co. W. Va.

16. Informant... Frank D. Timbrook

Address... Flintstone, Md.

17. Burial... Burial Date thereof... February 2, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory... Ebenezer Methodist Cemetery  
Location... E of Romney W. Va. - Route 50

18. Funeral director... John J. Hoffer  
Address... Chamberland, Md.  
19. Feb 1 19 47 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan 30 19 47 at 9:55 P.M.  
21. CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 19 47 to Jan 30 19 47  
and that I last saw him alive on Jan 30 19 47  
Immediate cause of death... Cerebral Apoplexy

Due to... Cerebral Apoplexy

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide... Date of...  
Where did injury occur? (City or town) (County) (State)

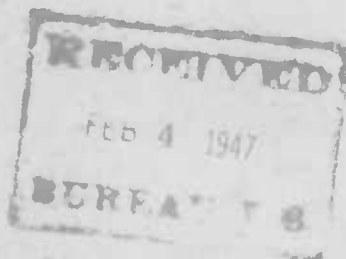
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work

23. SIGNATURE... R. B. Markers  
M. D. or other  
Address... 49 Greene St. Date signed... 2-7-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-365

102-1-100000-100000  
102-1-100000-100000  
102-1-100000-100000

R. WILLIAMS

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316

00094

## CERTIFICATE OF DEATH

Reg. Dist. No.

40

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 15 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Flintstone  
(If outside city or town limits, write RURAL and give nearest town)Street No. Route #2  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Carl A. Tribut

## 3. (b) Social Security Number

217-10-4607

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mary Ellen Rowe6. (c) If alive, give age 33 years

7. Birth data of deceased (mo., day, yr.)

September 1, 1904

8. AGE:

Years

Months

Days

If less than one day

4241

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Tavern Operator

11. Industry or business

Own

MOTHER

FATHER

12. Name August Tribut13. Birthplace Maryland14. Maiden name Margaret Rowan15. Birthplace Maryland

16. Informant

Margaret E. Boyden

Address

Homewood Addition, Cumberland, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

7 JAN 1947

(month) (day) (year)

Cemetery or crematory

St. Patrick's Cemetery

Location

Cumberland, Maryland

18. Funeral director

Louis Stein, Inc.

Address

Cumberland, Maryland

19.

Jan 6

19

47

(Date rec'd by registrar)

J. P. Franklin, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1947 at 6:15p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/18/46 1946 to 1/2/47 1947and that I last saw him alive on 1/2/47 1947

Immediate cause of death

Chronic  
Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Franklin, M.D.  
M. D. or other  
Address Cumberland, Md. Date signed 1/2/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 14 1947

BUREAU V 8

2-35

Within corporate SCHINDLER

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00095

Reg. Dist. No.

40

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

2 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 619 Henderson Avenue  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Ida B. Twigg

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female WhiteMarried6. (b) Name of husband or wife James E. Twigg

7. Birth date of

deceased (mo., day, yr.)

July 20, 18856. (c) If alive, give age. 71 years

8. AGE:

Years

Months

Days

If less than one day

6169

hrs.

min.

9. Birthplace Pennsylvania  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Kinser, George13. Birthplace Pennsylvania

MOTHER

14. Maiden name Mary Ellen Kinser15. Birthplace Pennsylvania16. Informant Memorial HospitalAddress Cumberland, Maryland17. Burial Date thereof Feb 1 '47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Grave Creek Cem.Location Cumberland18. Funeral director Louis Stein Inc.Address Cumberland Ind.19. Jan 31, 1947 J. P. Franklin M.D.  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1947 at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 25, 1947 to Jan 29, 1947  
 and that I last saw him alive on Jan 29, 1947

Immediate cause of death

Protein Poisoning

DURATION

3 days

Due to

Due to

Other conditions

Hypertension, A.V. block, chronic

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. M. Schindler M.D.

M.D. or other

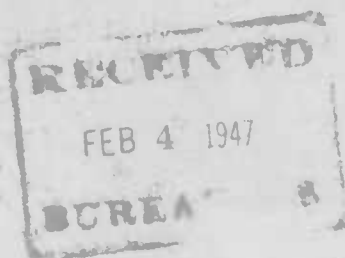
Address

41 Levee St

Date signed

Jan 31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Allegany  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Midlothian Road  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Katherine Whetstone

## 3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife Joseph Whetstone7. Birth date of deceased (mo., day, yr.) April 5, 1863 6. (c) If alive, give age. years

8. AGE: Years 83 Months 8 Days 27 If less than one day  
 hrs. min.

9. Birthplace Okonoko, W. Va.  
(Town, county, and state)10. Usual occupation housewife11. Industry or business Home12. Name Samuel House13. Birthplace Maryland14. Maiden name Elizabeth O. Farrell15. Birthplace Maryland16. Informant Mrs. Sambia WilliamsAddress Frostburg, Md.17. Burial Date thereof Jan 4, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory AlleganyLocation Frostburg, Md.18. Funeral director J. J. OuerstAddress Frostburg, Md.19. 1-3 19 47 Mrs. Nancy A. Roe  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 19 47, at 7:00 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 25 19 46, to Jan 2 19 47and that I last saw her alive on Jan 1 19 47Immediate cause of death the MyocarditisDue to Senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. M. Cline Jr. M.D. M. D. or otherAddress Frostburg, Md. Date signed 1-3-47

RECEIVED

JAN 6 1947

WHEAT & C

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

9

## 1. PLACE OF DEATH:

County Allegany  
 City or town Frostburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
1 Welch Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County ALLEGANY  
 City or town FROSTBURG  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1 WELCH ST.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Thomas W. Wilhelm

## 3. (b) Social Security Number

216-10-3429

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Effie Wilhelm  
 7. Birth date of deceased (mo., day, yr.) June 29, 1878 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 68 Months 7 Days 0 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Avilton, Garrett, Maryland  
(Town, county, and state)10. Usual occupation Janitor11. Industry or business Post office12. Name Nelson Wilhelm13. Birthplace Maryland14. Maiden name Ellen Mc Kenzie15. Birthplace Maryland16. Informant Mrs. Mary PariseAddress Frostburg Md.17. Burial Date this col. Jan 31, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Patrick'sLocation Sunderland Md.18. Funeral director J. J. HurstAddress Frostburg Md.19. 1-30 19 47 Mrs. Nancy N. Roe  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 29 January 19 47, at 7:20 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JANUARY 27 19 47 to JANUARY 28 19 47and that I last saw him alive on JANUARY 28 19 47Immediate cause of death CARDIAC FAILURE DURATIONDue to SERIOUS PERICARDITIS ?? 3 days?Due to PNEUMONIA - LOBAR - LOWER 15 daysLEFT LOBE ??Other conditions ADDISON'S DISEASE ?? ?

(Include pregnancy within 3 months of death)

Major findings of operations LTONE

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NONE

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Martin O'Brien M.D. M. D. or otherAddress 2 Broadway - Frostburg Md. Date signed 1/30/47

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1-35

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00098

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany County Infirmary

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 209 Avirett Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Richard Henry Willison Jr.

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Elizabeth Willison

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1881

8. AGE: Years 65 Months 3 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hyndman, Penna.  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Engineer for City

12. Name Richard H. Willison

13. Birthplace Maryland

14. Maiden name Jenevie Kelso

15. Birthplace Maryland

16. Informant Mr. Robert Willison

Address 209 Avirett Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan. 27, 1947  
(month) (day) (year)

Cemetery or crematory HillCrest Burial Park

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. Jan 27 1947 J. P. Franklin, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24, 1947 at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 3, 1946 to Jan 24, 1947  
and that I last saw him alive on Jan 2, 1947

Immediate cause of death Congestive Heart failure

Due to Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE Arthur F. Jones M.D.

M. D. or other

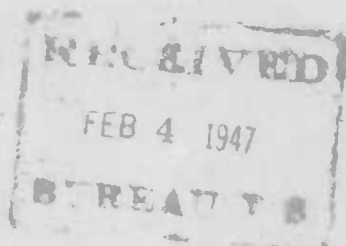
Address 110 S. Centre St. Date signed 1-27-47

MARGIN RESERVED FOR BINDING

9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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## CERTIFICATE OF DEATH

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County..... Allegany  
City or town..... Conaconnick  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 18 years  
Hospital, institution, or street address where death occurred:  
East Main Street  
How long in hospital or institution?..... 1

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County..... Allegany  
City or town..... Conaconnick  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... East Main Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... 1

### 3. (a) FULL NAME

Renneth Ellsworth Childs

### 3. (b) Social Security Number

1

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Child

6.(b) Name of husband or wife..... 1

7. Birth date of deceased (mo., day, yr.)..... Aug. 10, 1936 6.(c) If alive, give age..... 1 years

8. AGE: Years..... 10 Months..... 5 Days..... 13 If less than one day..... hrs. .... min.

9. Birthplace..... Cumberland, Allegany Co., Md.  
(Town, county, and state)

10. Usual occupation..... None

11. Industry or business..... None

12. Name..... John Ellsworth Childs

13. Birthplace..... Dist. Savage, Md.

14. Maiden name..... Mary Catherine Berry

15. Birthplace..... Conaconnick, Md.

16. Informant..... Mr. John C. Childs

Address..... Conaconnick, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereon..... Jan 26, 1947  
(month) (day) (year)

Cemetery or crematory..... Methodist Cemetery

Location..... Dist. Savage, Md.

18. Funeral director..... W. Eschhorn

Address..... Conaconnick, Md.

19. Jan 25 19 47 Jannette M. Gail  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 23, 1947 at..... 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 1/23/47 19..... to..... 1/23/47 19.....

and that I last saw him..... alive on..... 1/23/47 19.....

Immediate cause of death..... Septicemic Cerebral

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

Due to.....

Other conditions.....

Due to.....

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Due to.....

Other conditions.....

Due to.....

Other conditions.....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 30 1947

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 40

## 1. PLACE OF DEATH:

County Allegheny  
City or town Cambsland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

483 Central Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State Maryland County AlleghenyCity or town Cambsland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 483 Central Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Belle L. Wilson

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16, 18698. AGE: Years Months Days If less than one day  
77 3 3 hrs. min.9. Birthplace St. Va.  
(Town, county, and state)10. Usual occupation School teacher11. Industry or business Retired12. Name Annis F. Wilson13. Birthplace Va.14. Maiden name Mary Ann Burnette15. Birthplace Va.16. Informant Annis Burnette WilsonAddress Cambsland17. Burial Date thereof Jan 22 '47  
(Burial, cremation, or removal. Which? (month) (day) (year))Cemetary or crematory St. Peter & Pauls Ch.Location Cambsland18. Funeral director Annis Stein 9 moAddress Cambsland19. Jan 21 19 47 Ans. O. Draffler  
(Date rec'd by registrar) M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 19 47 at 6 P.

21. I CERTIFY that death occurred on the date above stated that I attended deceased from

Jan 1st 19 46 to Jan 19 19 47and that I last saw him alive on Jan 18 19 47

Immediate cause of death

Chronic myocarditis 2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. A. Truaskie, Jr M.D. or otherAddress Cambsland, Md Date signed 1/20/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 00101 60

## 1. PLACE OF DEATH:

County Allegany,City or town Westernport,  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Luther Wright.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed.

8. (b) Name of husband or wife

Jean Love Wright.

7. Birth date of

deceased (mo., day, yr.)

March 27, 1858.

8. AGE:

Years

Months

Days

If less than one day

88927

hrs.

min.

9. Birthplace

England.

(Town, county, and state)

10. Usual occupation

Retired Carpenter.

11. Industry or business

B. & O. Railroad Company.

MOTHER FATHER

12. Name

Benjamin Wright.

13. Birthplace

England.

14. Maiden name

Maria Harrison.

15. Birthplace

England.

16. Informant

Mrs. Smith Whitworth.

Address

Westernport, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan. 27, 1947  
(month) (day) (year)

Cemetery or crematory

Philos Cemetery.

Location

Westernport, Maryland.

18. Funeral director

W. Harold F. Fellsch

Address

Piedmont, West Va.

19. Date

(Date received by registrar)

19

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland.

County

Allegany,

City or town

Westernport,

(If outside city or town limits, write RURAL and give nearest town)

Street No.

139 Philos Avenue.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 24, 1947, at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 20, 1947, to Jan 24, 1947  
and that I last saw him alive on Jan 27th 1947

Immediate cause of death

Chronic Cardiac  
Vascular disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

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JAN 30 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00102

49

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 32 years  
 Hospital, institution, or street address where death occurred:  
351 Bedford St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 351 Bedford St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Pauline M. Yeider

## 3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Frank E. Yeider  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 26, 1883  
 8. AGE: Years 63 Months 9 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bedford Co., Pa.  
 (Town, county, and state)  
 10. Usual occupation Bookkeeper - Housekeeper  
 11. Industry or business Cessna Transportation Co.  
 12. Name Daniel Casteel  
 13. Birthplace Bedford Co., Pa.  
 14. Maiden name Martha Donahoe  
 15. Birthplace Bedford Co., Pa.

16. Informant Ralph Casteel  
 Address Corwin Hotel, Keyser, W. Va.  
 17. Burial Date thereof February 1, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Hillcrest Cemetery  
 Location Cumberland, Md.  
 18. Funeral director John J. Hofer  
 Address Cumberland, Md.  
 19. Jan 31 19 47 J. P. Franklin, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 19 47 at 7:00 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 15 19 46 to Jan 30 19 47and that I last saw him alive on January 29 19 47Immediate cause of death Cardio-Renal

## DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E. Keiser M. D. or other \_\_\_\_\_Address 122 Bedford St. Date signed 1/31/47

